

SERFF Tracking Number: CLTR-127385968 State: Arkansas
Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
Company Tracking Number: AH 200A OA AR F
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Occupational Accident
Project Name/Number: Occupational Accident Filing/

Filing at a Glance

Company: Atlantic Specialty Insurance Company

Product Name: Group Occupational Accident SERFF Tr Num: CLTR-127385968 State: Arkansas
TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved- State Tr Num: 49717
Closed

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: AH 200A OA AR F State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Disposition Date: 09/08/2011
Authors: Stephanie Young, Linda Ryan-James, Mark Swercheck,
Dana Suter, Michael Vogel
Date Submitted: 09/06/2011 Disposition Status: Approved-
Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Occupational Accident Filing
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Other

Overall Rate Impact:

Deemer Date:

Submitted By: Stephanie Young

Filing Description:

On behalf of Atlantic Specialty Insurance Company, Coulter and Associates is filing the attached occupational accident forms.

These forms were previously filed and approved for OneBeacon America Insurance Company and the only changes to the forms are the company name, form number and edition date.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type:

Independent Contractors

Filing Status Changed: 09/08/2011

State Status Changed: 09/08/2011

Created By: Dana Suter

Corresponding Filing Tracking Number:

SERFF Tracking Number: CLTR-127385968 State: Arkansas
 Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
 Company Tracking Number: AH 200A OA AR F
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Occupational Accident
 Project Name/Number: Occupational Accident Filing/

These forms were approved for OneBeacon America Insurance Company on 03/26/2007 in State Tracking Number 35132.

As with the OneBeacon America Insurance Company filing and approval previously referenced, bracketed language is either included or deleted and not amended within the brackets. Numerical data will continue to comply with state minimum requirements.

The forms will become effective upon approval.

If you have any questions, please call me at (609) 443-7540 or email me at stephaniey@coulter-and-associates.com. Otherwise we look forward to your approval.

Company and Contact

Filing Contact Information

Stephanie Young, Consultant stephaniey@coulter-and-associates.com
 C/O Coulter-and-associates.com 609-443-7540 [Phone]
 379 Princeton-Hightstown Rd 609-443-4103 [FAX]
 Suite 15
 Cranbury, NJ 08512

Filing Company Information

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

Atlantic Specialty Insurance Company	CoCode: 27154	State of Domicile: New York
One Beacon Lane	Group Code:	Company Type:
Canton, MA 02021	Group Name:	State ID Number:
(212) 428-6580 ext. [Phone]	FEIN Number: 13-3362309	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: \$50.00 per form filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
---------	--------	----------------	---------------

<i>SERFF Tracking Number:</i>	<i>CLTR-127385968</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Atlantic Specialty Insurance Company</i>	<i>State Tracking Number:</i>	<i>49717</i>
<i>Company Tracking Number:</i>	<i>AH 200A OA AR F</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Group Occupational Accident</i>		
<i>Project Name/Number:</i>	<i>Occupational Accident Filing/</i>		
<i>Atlantic Specialty Insurance Company</i>	<i>\$50.00</i>	<i>09/06/2011</i>	<i>51262806</i>
<i>Atlantic Specialty Insurance Company</i>	<i>\$200.00</i>	<i>09/07/2011</i>	<i>51309174</i>

SERFF Tracking Number: CLTR-127385968 State: Arkansas
 Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
 Company Tracking Number: AH 200A OA AR F
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Occupational Accident
 Project Name/Number: Occupational Accident Filing/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/08/2011	09/08/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/07/2011	09/07/2011	Stephanie Young	09/07/2011	09/07/2011

SERFF Tracking Number: CLTR-127385968 *State:* Arkansas
Filing Company: Atlantic Specialty Insurance Company *State Tracking Number:* 49717
Company Tracking Number: AH 200A OA AR F
TOI: H02G Group Health - Accident Only *Sub-TOI:* H02G.000 Health - Accident Only
Product Name: Group Occupational Accident
Project Name/Number: Occupational Accident Filing/

Disposition

Disposition Date: 09/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CLTR-127385968 *State:* Arkansas
Filing Company: Atlantic Specialty Insurance Company *State Tracking Number:* 49717
Company Tracking Number: AH 200A OA AR F
TOI: H02G Group Health - Accident Only *Sub-TOI:* H02G.000 Health - Accident Only
Product Name: Group Occupational Accident
Project Name/Number: Occupational Accident Filing/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Form	Occupational Accident Policy	Approved-Closed	Yes
Form	Occupational Accident Certificate of Insurance	Approved-Closed	Yes
Form	Administrative Change Endorsement	Approved-Closed	Yes
Form	Policyholder Application	Approved-Closed	Yes
Form	Driver Enrollment and Beneficiary Form	Approved-Closed	Yes

SERFF Tracking Number: CLTR-127385968 State: Arkansas
Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
Company Tracking Number: AH 200A OA AR F
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Occupational Accident
Project Name/Number: Occupational Accident Filing/

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 09/07/2011

Submitted Date 09/07/2011

Respond By Date

Dear Stephanie Young,

This will acknowledge receipt of the captioned filing.

Objection 1

- Occupational Accident Policy, AH 200A OA AR 08 11 (Form)
- Occupational Accident Certificate of Insurance, AH 202A OA AR 08 11 (Form)
- Administrative Change Endorsement, AH 203A OA CW 08 11 (Form)
- Policyholder Application, AH 204A OA AR 08 11 (Form)
- Driver Enrollment and Beneficiary Form, AH 205A OA AR 08 11 (Form)

Comment:

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

The fee for this submission is \$50.00 per form for a total of \$250.00. Please submit an additional \$200.00 for this submission.

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

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: CLTR-127385968 State: Arkansas
Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
Company Tracking Number: AH 200A OA AR F
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Occupational Accident
Project Name/Number: Occupational Accident Filing/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/07/2011
Submitted Date 09/07/2011

Dear Rosalind Minor,

Comments:

This is in response to your objection letter dated 9/7/11.

Response 1

Comments: The additional filing fee of \$200.00 has been submitted via EFT.

Related Objection 1

Applies To:

- Occupational Accident Policy, AH 200A OA AR 08 11 (Form)
- Occupational Accident Certificate of Insurance, AH 202A OA AR 08 11 (Form)
- Administrative Change Endorsement, AH 203A OA CW 08 11 (Form)
- Policyholder Application, AH 204A OA AR 08 11 (Form)
- Driver Enrollment and Beneficiary Form, AH 205A OA AR 08 11 (Form)

Comment:

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

The fee for this submission is \$50.00 per form for a total of \$250.00. Please submit an additional \$200.00 for this submission.

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

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number: CLTR-127385968 State: Arkansas
 Filing Company: Atlantic Specialty Insurance Company State Tracking Number: 49717
 Company Tracking Number: AH 200A OA AR F
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Occupational Accident
 Project Name/Number: Occupational Accident Filing/

Form Schedule

Lead Form Number: AH 200A OA AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/08/2011	AH 200A OA AR 08 11	Policy/Cont ract/Fratern al Certificate	Occupational Accident Policy	Initial		0.000	ASIC 200A OA AR Policy.pdf
Approved-Closed 09/08/2011	AH 202A OA AR 08 11	Certificate	Occupational Accident Certificate of Insurance	Initial		0.000	ASIC 202A OA AR Certificate.pdf
Approved-Closed 09/08/2011	AH 203A OA CW 08 11	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Administrative Change Endorsement	Initial		0.000	ASIC 203A OA CW Administrative Change Endorsement. pdf
Approved-Closed 09/08/2011	AH 204A OA AR 08 11	Application/ Enrollment Form	Policyholder Application	Initial		0.000	ASIC 204A OA AR Policyholder Application.pdf
Approved-Closed 09/08/2011	AH 205A OA AR 08 11	Application/ Enrollment Form	Driver Enrollment and Beneficiary Form	Initial		0.000	ASIC 205A OA AR Driver Enrollment and Beneficiary Form.pdf



OCCUPATIONAL ACCIDENT POLICY
FOR
[POLICYHOLDER]

IMPORTANT NOTICE

**THIS POLICY IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A
SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE**

**THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY
IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR
LOSSES DUE TO SICKNESS**

**AND IT DOES NOT COVER ANY PERSON WHO IS REQUIRED TO BE COVERED BY A
WORKERS' COMPENSATION POLICY**

This Policy is a Legal Contract between the Policyholder and the Insurer.

Please read this Policy carefully.

Atlantic Specialty Insurance Company
[1 Beacon Lane
Canton, MA 02021-1030]

POLICYHOLDER: [ABC Company]
[123 Street
City, State 12345]

POLICY NUMBER: [1234567]

POLICY EFFECTIVE DATE: [January 1, 2007]

POLICY ANNIVERSARY DATE: [January 1st]

**[COVERED SUBSIDIARIES OR
AFFILIATED COMPANIES** [Names of Companies]]

This Policy is a legal contract between the Policyholder and the Insurer. The Insurer agrees to insure Eligible Persons of the Policyholder, for whom premium is paid, against loss covered by this Policy, subject to its provisions, limitations and exclusions.

This Policy takes effect on the Policy Effective Date. All periods of insurance begin and end when 12:01 AM, Standard Time occurs at the Policyholder's address. This Policy remains in force for the period for which premium has been paid.

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

In Witness Whereof, We have caused this Policy to be executed and attested, and, if required by state law, this Policy shall not be valid unless countersigned by our authorized representative.



Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company



Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Countersigned _____
Authorized Representative Date

READ THIS POLICY CAREFULLY

Table of Contents

Provision	Section
Eligibility, Effective Date and Termination Date.....	I
Schedule of Benefits.....	II
Premium.....	III
Benefits.....	IV
Limitations.....	V
General Exclusions.....	VI
Termination of Policy.....	VII
Claims Provisions.....	VIII
General Provisions.....	IX
General Definitions.....	X

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY

The following persons are eligible to become **Insured Persons** [provided they are [eighteen (18)] years of age and under **Dispatch** an average of [thirty (30)] hours each week (i.e. **Actively at Work**):

Class I:

[All **Actively at Work Owner-Operators** who enroll for coverage under this **Policy**. For purposes of this **Policy** an **Owner-Operator** must lease to or from the **Policyholder** and must:

1. have a valid and current Commercial Driver's License;
2. own or lease a power unit;
3. be responsible for the maintenance of the power unit;
4. be responsible for the operating costs of the power unit, including but not limited to fuel, repairs, supplies and other expenses associated with the operation of the power unit;
5. be responsible for maintaining physical damage insurance on the power unit;
6. be responsible for hiring and supervising personnel who operate the power unit;
7. be compensated on a basis other than time expended in the performance of work;
8. be responsible for determining the route and hours for an assignment;
9. have the right to select the load;
10. have a written contract or assignment from the person who has engaged his or her services which provides that he or she is an independent contractor;
11. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose; [and]
12. [not be an employee of the **Policyholder**;] [and]
13. [receive a 1099 form for federal income tax reporting purposes, not a W-2.]

[Class II:]

[All **Actively at Work Contract Drivers** who enroll for coverage under this **Policy**. For purposes of this **Policy**, a **Contract Driver** must:

1. have a valid and current Commercial Driver's License;
2. be authorized by an **Owner-Operator** or motor carrier to operate a power unit owned or leased by an **Owner-Operator**. (The **Contract Driver** must neither own nor lease the power unit.);
3. be compensated on a basis other than time expended in the performance of work;
4. be responsible for determining the route and hours for an assignment;
5. operate the power unit of the person who has engaged his or her services as an independent contractor. (Operating the unit must be the principal duty of the **Contract Driver**.)
6. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;
7. [receive a 1099 form for federal income tax reporting purposes, not a W-2;
8. [not be an employee of the **Policyholder**;]
9. [not be an employee of the **Owner-Operator**;] [and]
10. [not be an employee of the **Policyholder** or **Owner-Operator** unless it is not mandatory for workers' compensation coverage to be provided for such person as an employee of either the **Policyholder** or an **Owner-Operator**.]

[Class III:]

[As requested by the **Policyholder**]

The **Insured Person** cannot be covered by any other **Occupational Accident Policy** issued by **Us**.

If the **Insured Person** pays premium but is not eligible for coverage or does not qualify for benefits under this **Policy**, **We** will refund any premium paid in error.

INSURED PERSON'S EFFECTIVE DATE

Class I-[Owner-Operator]: [An [Owner-Operator's] coverage under this **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date the person becomes a member of an eligible Class as described above;
3. if an individual enrollment form is required, the date the completed enrollment form is received by the **Policyholder** or an authorized person designated by the **Policyholder**.]

Class II]-[Contract Driver]: [A [Contract Driver's] coverage under this **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date the person becomes a member of an eligible Class as described above;
3. if an individual enrollment form is required, the date the completed enrollment form is received by the **Policyholder** or an authorized person designated by the **Policyholder**.]

Class III]-[as requested by Policyholder]: [as requested by **Policyholder**]

[Coverage will not become effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of 1, 2 or 3 above. If premium is not paid when due, coverage will not be in effect.]

INSURED PERSON'S TERMINATION DATE

Class I-[Owner-Operator]: [An [Owner-Operator's] coverage under this **Policy** ends on the earliest of:

1. the date this **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period;
3. the date the [Owner-Operator] requests, in writing, that his or her coverage be terminated; or
4. the date the [Owner-Operator] ceases to be a member of an eligible Class as described above.]

Class II]-[Contract Driver]: [A [Contract Driver's] coverage under this **Policy** ends on the earliest of:

1. the date this **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period;
3. the date the [Contract Driver] requests, in writing, that his or her coverage be terminated;
4. the date the [Contract Driver] ceases to be a member of an eligible Class as described above; or
5. [the date the [Owner-Operator], with respect to whom the [Contract Driver] is under contract, ceases to be a member of an eligible Class as described above.]]

Class III]-[as requested by Policyholder]: [as requested by **Policyholder**]

A change in an **Insured Person's** coverage under this **Policy**, due to a change in the **Insured Person's** eligible Class or benefit selection, becomes effective on the later of: (1) the date the change in his or her eligible Class or benefit selection occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Covered Accidents** that occur after the change becomes effective.

Subject to the terms, conditions, exclusions and limitations of this **Policy**, termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while the **Insured Person's** coverage was in force under this **Policy**.

SECTION II – SCHEDULE OF BENEFITS

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum *[\$50,000]
Accident Commencement Period..... [365 days]

Survivor's Benefit:

Principal Sum *[\$175,000]
[Monthly Benefit Percentage.....[1.0%]]
[Monthly Benefit Amount[\$1,750]]

Accidental Dismemberment Benefit:

Principal Sum *[\$225,000]
Accident Commencement Period..... [365 days]

Paralysis Benefit:

Principal Sum *[\$225,000]
Accident Commencement Period..... [365 days]

Temporary Total Disability Benefit:

Disability Commencement Period..... [90 days]
Waiting Period [7 days]
Benefit Percentage.....[66.67%]
Minimum Weekly Benefit Amount..... [\$125]
Maximum Weekly Benefit Amount [\$475]
Maximum Benefit Period **..... [104 weeks]
[**Maximum Benefit Period** for Hernia.....[10 weeks]]
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**
and/or **Repetitive Conditions**[10 weeks]]

Continuous Total Disability Benefit: ***

Waiting Period [Maximum Benefit Period for Temporary Total Disability]
Benefit Percentage.....[66.67%]
Minimum Weekly Benefit Amount..... [\$50]
Maximum Weekly Benefit Amount [\$475]
Maximum Benefit Amount.....[\$300,000]
Maximum Benefit Period [to age 70]

Accident Medical Expense Benefit:

Medical Commencement Period [90 days]
Deductible Amount.....[\$0]
Maximum Benefit Period.....[104 weeks]
Dental Maximum[\$1,000.00 per **Accident**]
Maximum Benefit Amount per Accident[\$750,000]
Lifetime Maximum Benefit[\$100,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy.....[[\$1,000] per **Injury**]
[and] [a combined [36] visits]
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
Occupational Therapy, Work Hardening Therapy..... [\$1,000] per **Injury**
Ambulance..... [[one] round trip to and from a **Hospital**]
[but] [not more than [\$1,000] for any one **Accident**]
[Air Ambulance.....[[one] round trip to and from a **Hospital**]
[but] [not more than [\$7,000] for any one **Accident**]]

[Hernia Coverage.....lifetime **Maximum Benefit** of [\$10,000]]
Mental and Nervous – Outpatient..... [[\$25.00] per visit]
[maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient..... [maximum [20] days]
[maximum [\$1,000] for any one **Accident**]
[**Occupational Cumulative Trauma** and/or
Repetitive Conditions..... lifetime **Maximum Benefit** of [\$10,000]]

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$750,000]
- **Aggregate Limit of Liability** [\$1,500,000]
(applicable to all **Covered Losses** with respect to any one **Occupational Accident**)
- [Hernia Coverage.....combined lifetime **Maximum Benefit** of [\$15,000]]
- [**Occupational Cumulative Trauma** and/or **Repetitive Conditions**
.....combined lifetime **Maximum Benefit** of [\$15,000]]
- [**Pre-Existing Condition** Limitation [\$10,000]]

*At age [65], the **Insured Person's Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	[80%]
66	[60%]
67	[40%]
68	[20%]
69	[15%]
[70 and over]	[10%]

** If an **Insured Person** sustains a **Covered Injury** at or after age [70], the **Maximum Benefit Period** will be [one (1) year].

***If an **Insured Person** sustains a **Covered Injury** after the **Insured Person's** normal Social Security retirement age, as determined by federal law, the **Insured Person** cannot qualify for **Continuous Total Disability**.

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum *[\$7,500]
Accident Commencement Period.....[365 days]

Accidental Dismemberment Benefit:

Principal Sum *[\$7,500]
Accident Commencement Period.....[365 days]

Accident Medical Expense Benefit:

Medical Commencement Period.....[90 days]
Deductible Amount[\$0]
Maximum Benefit Period.....[52 weeks]
 Dental Maximum[\$1,000 per **Accident**]
Maximum Benefit Amount per Accident.....[\$5,000]
Lifetime Maximum Benefit[\$10,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy..... [[\$1,000] per **Injury**]
 [and][a combined [36] visits]
 Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
 Occupational Therapy, Work Hardening Therapy [\$1,000] per **Injury**
 Ambulance [[one] round trip to and from a **Hospital**]
 [but][not more than [\$1,000] for any one **Accident**]
 [Air Ambulance.....[[one] round trip to and from a **Hospital**]
 [but][not more than [\$7,000] for any one **Accident**]]
Mental and Nervous – Outpatient..... [[\$25.00] per visit]
 [maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient.....[maximum [20] days]
 [maximum [\$1,000] for any one **Accident**]

NON-OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$7,500]
- **Aggregate Limit of Liability**..... [\$15,000]
 (applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

* At age [65], the **Insured Person's Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	[80%]
66	[60%]
67	[40%]
68	[20%]
69	[15%]
[70 and over]	[10%]

SECTION III – PREMIUM

Premium Due Date: [01/01/2007] and 1st of each month thereafter

Premium Amount:

Class I: \$[0.00] per [Owner-Operator] per month
[Class II:] [\$[0.00] per [Contract Driver] per month]
[Class III:] [\$[0.00] per [as requested by Policyholder] per month]

An **Insured Person** who enrolls on or prior to the fifteenth of the month will pay an amount equal to the full monthly premium. No premium will be payable for the last full or partial month of coverage.

An **Insured Person** who enrolls after the fifteenth of the month will pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, the **Insured Person** will pay an amount equal to the monthly premium.

Grace Period:

For the **Policy**: A Grace Period of [ninety (90)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during the Grace Period if the **Policyholder** pays all premiums due by the last day of the **Policy** Grace Period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of the **Policy** Grace Period.

If **We** expressly agree to accept late payment of a premium without terminating this **Policy**, **We** do so in accordance with the Noncompliance With **Policy** Requirements provision in the GENERAL PROVISIONS Section of this **Policy**. In such case, the **Policyholder** will be liable to **Us** for any unpaid premiums for the time this **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by **Us** in the collection of all overdue amounts.

No Grace Period will be provided if **We** receive notice to terminate this **Policy** prior to a premium due date.

For the **Insured Person**: A Grace Period of [thirty (30)] days will be provided for the payment of any premium due after the first premium. The **Insured Person's** coverage will not be terminated for nonpayment of premium during the Grace Period if the **Insured Person** pays the premiums due by the last day of the Grace Period. The **Insured Person's** coverage will terminate if all premiums due are not paid by the last day of the Grace Period.

No Grace Period will be provided if **We** receive notice to terminate the **Insured Person's** coverage prior to a premium due date.

Change of Premium Amount: Premiums are payable to **Us** at the rates and in the manner described above. **We** may change the required premiums due by giving the **Policyholder** at least [sixty (60)] days advance written notice. **We** may change the required premiums as a condition of any renewal of this **Policy**. **We** may also change the required premiums at any time when any change affecting premiums is made in this **Policy**.

We may re-underwrite and may change the terms and conditions of this **Policy**, including the premium rate, on the date when the number of **Insured Persons** under this **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [15%] or more. The **Policyholder** will provide **Us** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

Waiver of Premium: Subject to this **Policy** remaining in force, all premiums due under this **Policy** with respect to an **Insured Person** receiving either a **Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit under this **Policy** will be waived. Premiums will be waived from the first premium due date on or after the date the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit begins. Premium payments must be resumed on the premium due date next following the date the **Insured Person's Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit ceases. If premium payments are not resumed on that date, the **Insured Person's** coverage under this **Policy** will end on that date. The **Insured Person** is responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or **Us**.

SECTION IV – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Injury** to an **Insured Person** results in death within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the **Principal Sum** shown in the **Schedule**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If the **Insured Person** suffers an **Accidental** Death such that an **Accidental** Death Benefit is payable under this **Policy**, **We** will pay the beneficiary in accordance with the Payment of Claims provision.

Survivor's Benefit

The Monthly Benefit Amount will be as described in the **Schedule**. The Monthly Benefit Amount will be paid to the surviving **Spouse** up to the **Principal Sum** shown in the **Schedule**.

If the **Insured Person** is not survived by a **Spouse**, or if the **Insured Person's Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to the **Insured Person's** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date the **Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date the last **Dependent Child** dies or is no longer eligible as defined in the GENERAL DEFINITIONS Section of this **Policy**; or
3. the date the **Principal Sum** has been paid.

If the **Insured Person** is not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will pay only the **Accidental** Death Benefit in accordance with the Payment of Claims provision of this **Policy**. **We** will not pay a Survivor's Benefit.

Exposure and Disappearance

If an **Insured Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the body of an **Insured Person** has not been found within 365 days after the disappearance, stranding, sinking or wrecking of a [power unit] in which that person was an occupant, then it will be presumed, subject to all other terms and provisions of this **Policy**, that the **Insured Person** has suffered **Accidental** Death within the meaning of this **Policy**. If the **Insured Person** is subsequently found alive and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to an **Insured Person** results in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

<u>For Covered Loss of:</u>	<u>Percentage of the Principal Sum</u>
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]

For purposes of the **Accidental Dismemberment Benefit**, **Loss** will mean:

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one **Loss** is sustained by an **Insured Person** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

PARALYSIS BENEFIT (does not apply to a **Non-Occupational Accident**)

If a **Covered Injury** to an **Insured Person** results in any Type of Paralysis specified below, within the **Accident Commencement Period** shown in the **Schedule**, We will pay the Percentage of the **Principal Sum** indicated below.

<u>Type of Paralysis:</u>	<u>Percentage of the Principal Sum</u>
Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**. **Paraplegia** means the complete and irreversible paralysis of both lower **Limbs**. **Hemiplegia** means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body. **Uniplegia** means the complete and irreversible paralysis of one **Limb**. For purposes of this benefit **Limb** means entire arm or entire leg.

If the **Insured Person** sustains more than one Type of Paralysis as a result of the same **Covered Accident**, only the largest single amount will be considered a **Covered Loss**.

TEMPORARY TOTAL DISABILITY (TTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

TTD Benefit Qualifications.

If a **Covered Injury** to an **Insured Person** results in **Temporary Total Disability** within the **Disability Commencement Period** shown in the **Schedule**, We will pay the **Temporary Total Disability** Benefit specified below, subject to satisfaction of any applicable **Waiting Period** shown in the **Schedule**. The **Disability Commencement Period** starts on the date of the **Accident** that caused such **Injury**. After the **Waiting Period** has been satisfied, the **Temporary Total Disability** Benefit will be payable from the day the **Waiting Period** was satisfied.

TTD Benefit Amount.

The **Temporary Total Disability** Benefit with respect to each week of an **Insured Person's Temporary Total Disability** during a **Single Period of Total Disability** is equal to the lesser of:

1. the Benefit Percentage (as shown in the **Schedule**) of the **Insured Person's Average Weekly Earnings**; or
2. the **Maximum Weekly Benefit Amount** shown in the **Schedule**.

In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Temporary Total Disability** Benefit with respect to less than a full **Benefit Week** of **Temporary Total Disability** equals 1/7th of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

TTD Benefit Calculation.

For the purposes of this **Temporary Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- For Class I [**Owner-Operators**]:
[[Thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown in his or her federal income tax return with schedules or 1099s, divided by 52, regardless of his or her prior occupation. If the **Insured Person** worked less than [fifty (50)] weeks during the prior year, then [thirty-three percent (33%)] of the gross income received in the prior year as shown in his or her federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of his or her prior occupation. The **Insured Person** will have to produce proof, which is satisfactory to Us, of the number of weeks worked, if he or she is claiming less than [fifty (50)] weeks.]
- [For Class II] [**Contract Drivers**]:
[[Seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown in his or

her federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of his or her prior occupation. If the **Insured Person** worked less than [fifty (50)] weeks during the prior year, then [seventy-five percent (75%)] of the gross income received in the prior year as shown in his or her federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of his or her prior occupation. The **Insured Person** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if he or she is claiming less than [fifty (50)] weeks.]

If the **Insured Person** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but has worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. The **Insured Person** will have to produce proof, which is satisfactory to **Us**, of his or her gross income and the number of weeks worked.

If the **Insured Person** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and has not worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will award the **Insured Person** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

TTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which the **Insured Person's Dependents** may qualify because of the **Insured Person's** Disability; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing the **Insured Person's** power unit. The **Insured Person** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

TTD Benefit Termination.

The **Temporary Total Disability** Benefit will cease on the earliest of the following dates:

1. the date the **Insured Person** is no longer **Temporarily Totally Disabled**;
2. the date the **Maximum Benefit Period** shown in the **Schedule** has been reached;
3. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
4. the date the **Insured Person** dies.

TTD Benefit Definitions.

As used in this **Temporary Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the first day of **Temporary Total Disability** after the **Waiting Period** shown in the **Schedule** for **Temporary Total Disability**, and on the same day of each week thereafter.

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

Disability Commencement Period means the time period, shown in the **Schedule**, between the date of the **Accident** that caused the **Injury** and the date that **Temporary Total Disability** must begin for disability benefits to be payable under this **Policy**.

Maximum Benefit Period means, with respect to **Temporary Total Disability**, the maximum period for which benefits will be payable for a **Temporary Total Disability Covered Loss** during a **Single Period of Total Disability**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Temporary Total Disability** is shown in the **Schedule**.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following which are considered separate periods of disability: (1) successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which the **Insured Person** is not **Temporarily Totally Disabled**; (2) successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least 6 months during which the **Insured Person** is not **Temporarily Totally Disabled**.

Temporary Total Disability or **Temporarily Totally Disabled** means disability that: (1) prevents an **Insured Person** from performing the **Material and Substantial Duties** of his or her occupation [as a commercial truck driver]; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, the **Insured Person** receiving

Continuous Care. If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** will not qualify for the **Temporary Total Disability** Benefit.

[For purposes of this section "**Material and Substantial Duties**" will mean a duty or duties which the **Insured Person** is required to perform as an [Owner-Operator] [or] [Contract Driver].]

CONTINUOUS TOTAL DISABILITY (CTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

CTD Benefit Qualifications.

If a **Covered Injury** to an **Insured Person** resulting in **Temporary Total Disability**, subsequently results in **Continuous Total Disability**, We will pay the **Continuous Total Disability** Benefit specified below, provided:

1. the benefits payable for the **Temporary Total Disability Covered Loss** ceased solely because the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached, but the **Insured Person** remains disabled;
2. the **Insured Person** is under the normal Social Security retirement age, as determined by federal law, on the day after the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached;
3. the **Insured Person** has been granted a Social Security Disability Award for his or her disability (If the **Insured Person** cannot meet the credit requirement for a Social Security Award, he or she cannot qualify for the **Continuous Total Disability** Benefit even if he or she would otherwise qualify);
4. the **Insured Person's** disability is reasonably expected to continue without interruption until the **Insured Person** dies, and is substantiated by objective medical evidence satisfactory to Us;
5. the **Injury** began within the **Disability Commencement Period** shown in the **Schedule**; and
6. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**. (If the **Temporary Total Disability** was principally due to a **Mental and Nervous or Depressive Condition**, the **Insured Person** does not qualify for a **Continuous Total Disability** Benefit.)]

An **Insured Person** cannot qualify for a **Continuous Total Disability** Benefit unless the **Insured Person** qualified for a **Temporary Total Disability** Benefit for the same **Covered Injury**.

Sunset Period: If the **Insured Person** is not granted a Social Security Award for his or her disability within two (2) years of the **Injury**, the **Insured Person** cannot qualify for a **Continuous Total Disability** Benefit even if he or she would otherwise qualify.

CTD Benefit Amount.

The **Weekly Benefit Amount** will be the lesser of the benefit percentage, as shown in the **Schedule**, of the **Average Weekly Earnings**, or the **Maximum Weekly Benefit Amount** as shown in the **Schedule**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Continuous Total Disability** Benefit with respect to less than a full **Benefit Week** of **Continuous Total Disability** equals 1/7th of the **Weekly Benefit** for each day of **Continuous Total Disability**.

CTD Benefit Calculation.

For purposes of this **Continuous Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- For Class I [**Owner-Operators**]:
[[Thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown in his or her federal income tax return with schedules or 1099s, divided by 52, regardless of his or her prior occupation. If the **Insured Person** worked less than [fifty (50)] weeks during the prior year, then [thirty-three percent (33%)] of the gross income received in the prior year as shown in his or her federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of his or her prior occupation. The **Insured Person** will have to produce proof, which is satisfactory to Us, of the number of weeks worked if he or she is claiming less than [fifty (50) weeks].]
- [For Class II] [**Contract Drivers**]:
[[Seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown in his or her federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of his or her prior occupation. If the **Insured Person** worked less than [fifty (50)] weeks during the prior year, then [seventy-five percent (75%)] of the gross income received in the prior year as shown in his or her federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of his or her prior occupation. The **Insured Person** will have to produce proof, which is satisfactory to Us, of the number of weeks worked, if he or she is claiming less than [fifty (50) weeks].]

If the **Insured Person** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but has worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. The **Insured Person** will have to produce proof, which is satisfactory to **Us**, of his or her gross income and the number of weeks worked.

If the **Insured Person** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and has not worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will award the **Insured Person** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

CTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which the **Insured Person's Dependents** may qualify because of the **Insured Person's Disability**; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing the **Insured Person's** power unit. The **Insured Person** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CTD Benefit Termination.

The **Continuous Total Disability** Benefit will cease on the earliest of the following dates:

1. the date the **Insured Person** is no longer **Continuously Totally Disabled**;
2. the date the **Insured Person's** Social Security Disability Award ceases;
3. the date the **Insured Person** attains age [70];
4. the date the **Maximum Benefit Period** shown in the **Schedule** for **Continuous Total Disability** has been reached;
5. the date the **Maximum Benefit Amount** shown in the **Schedule** for **Continuous Total Disability** has been reached;
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
7. the date the **Insured Person** dies.

CTD Benefit Definitions.

As used in this **Continuous Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Care means at least quarterly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Continuous Total Disability** on a quarterly basis. These requirements may be waived by **Us**.

Continuous Total Disability or **Continuously Totally Disabled** means disability that: (1) prevents an **Insured Person** from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, the **Insured Person** receiving **Continuous Care**. If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** will not qualify for a **Continuous Total Disability** Benefit.

If the **Insured Person** can perform an occupation which would provide an annual gross income equal to or greater than either the gross income from wages and/or the net income reported on Schedule C which the **Insured Person** filed on his or her most recent federal income tax return filed prior to the **Covered Injury**, the **Insured Person** is not **Continuously Totally Disabled**. The **Insured Person** must provide **Us** with such federal income tax return in order to qualify for a **Continuous Total Disability** Benefit.

Maximum Benefit Amount means, with respect to **Continuous Total Disability**, the maximum benefits payable for **Continuous Total Disability Covered Losses**.

Maximum Benefit Period means, with respect to **Continuous Total Disability**, the maximum period for which benefits will be payable for a **Continuous Total Disability Covered Loss**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Continuous Total Disability** is shown in the **Schedule**. Benefits payable under the **Temporary Total Disability** Benefit will not be considered **Continuous Total Disability** Benefits for purposes of applying the **Maximum Benefit Period**.

Terms used in this **Continuous Total Disability** Benefit, but which refer to **Temporary Total Disability** and are defined in the **Temporary Total Disability** Benefit, are to be interpreted as defined in that Benefit.

ACCIDENT MEDICAL EXPENSE (AME) BENEFIT

AME Benefit Qualifications.

If an **Insured Person** suffers an **Injury** that requires him or her to be treated by a **Physician**, within the **Medical Commencement Period** shown in the **Schedule**, We will pay the **Usual and Customary Charges** incurred for **Medically Necessary Covered Accident Medical Services** received due to that **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown in the **Schedule**, per **Insured Person**, for all **Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Injury**. The **Deductible Amount** for the **Accident Medical Expense** Benefit is the **Deductible Amount** shown in the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Injuries** sustained by the **Insured Person** in that **Covered Accident**. [If the **Injury** is related to a **Pre-Existing Condition**, the **Accident Medical Expense** Benefit will be subject to the limit as shown in the **Schedule**.]

AME Benefit Covered Accident Medical Services.

1. **Hospital** semi-private room and board (or room and board in an intensive care unit), **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
2. Services of a **Physician** or a qualified nurse, if under the supervision of a Graduate Registered Nurse (RN), for **Home Health Care** which follows a [five (5)] day period of **Hospital** confinement and which is prescribed by a **Physician**;
3. Services by a qualified **Physician** for the treatment of a covered **Mental and Nervous Condition** due to a **Covered Injury**. However, such charges will be considered a **Covered Accident Medical Expense** only to the extent that the charges do not exceed [\$25.00] per visit and are further limited to one visit per day with a maximum of [twenty (20)] visits. **Hospital** charges for in-patient treatment of a **Mental and Nervous Condition**, whether in a psychiatric **Hospital** or a general **Hospital**, will be considered a **Covered Accident Medical Expense** and will be limited to up to a [twenty (20)] day inpatient maximum;
4. Ambulance, including air ambulance, service to or from a **Hospital** for [one] round trip;
5. Laboratory tests;
6. Radiological procedures;
7. Anesthetics and the administration of anesthetics;
8. Blood, blood products and artificial blood products, and the transfusion thereof;
9. Physical Therapy, Occupational Therapy, Work Hardening Therapy and Chiropractic or Acupuncturist Care as shown in the **Schedule**;
10. Rental of **Durable Medical Equipment**, up to the actual purchase price of such equipment;
11. The initial supply, but not replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes subject to the **Accident Medical Expense** Benefit Exclusions section;
12. Medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
13. Repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the Dental Maximum, if any, shown in the **Schedule**.
14. **Extended Care Facilities**; or
15. **Home Health Care**.

The foregoing **Covered Accident Medical Services** are subject to all of the limits as shown in the **Schedule**.

AME Benefit Exclusions.

In addition to the GENERAL EXCLUSIONS in SECTION VI of this **Policy**, charges for **Covered Accident Medical Services** do not include, and benefits are not payable with respect to, any expense for or resulting from:

- repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
- dentures, bridges, dental implants, or treatment not related to the **Injury**;

- eye glasses or contact lenses;
- hearing aids or hearing examinations;
- that portion of rental expense for **Durable Medical Equipment** that exceeds the usual purchase cost for similar equipment in the locality where the expense is incurred;
- **Custodial Services;**
- **Personal Comfort or Convenience Items;**
- services of a Federal, Veteran's, State or Municipal **Hospital** for which an **Insured Person** is not liable for payment;
- services or treatment which is covered by Medicare;
- that portion of the fee for services or treatment which is more than the **Usual and Customary Charge;**
- cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of an **Injury;**
- services or treatment which are provided for in a settlement or court judgment;
- services or treatment which are covered under any other insurance of any kind;
- services or treatment for which an **Insured Person** is not legally obligated to pay;
- an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
- any mileage charges related to the **Covered Injury** unless authorized by **Us;**
- any translation charges related to the **Covered Injury** unless authorized by **Us;** or
- any lodging charges related to the **Covered Injury** unless authorized by **Us.**

AME Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Ambulatory Medical Center means a facility that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.

Custodial Services means any services which are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services: (1) related to watching or protecting the **Insured Person;** (2) related to performing or assisting the **Insured Person** in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and (3) that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Extended Care Facility means an institution that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. is approved by the Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a Graduate Registered Nurse (RN);
5. provides skilled nursing care under the supervision of a **Physician;** and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of an **Insured Person** in his or her home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:

1. be approved in writing by the attending **Physician;**

2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
3. begin within [seven (7)] days after discharge from a **Hospital**; and
4. follow a **Hospital** confinement of [five (5)] days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of an **Insured Person's** immediate family; or
2. a person residing in the **Insured Person's** home.

Hospital means a facility that: (1) operates under the law of the state that it is situated in; (2) is approved by the Department of Health and Human Services or its successor; (3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and (5) is supervised by one or more **Physicians**. A **Hospital** does not include: (1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or (3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Maximum Benefit Period means, with respect to the **Accident Medical Expense** Benefit, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The length of the **Maximum Benefit Period** for **Accident Medical Expense** is shown in the **Schedule**.

Medical Commencement Period means the time period shown in the **Schedule** between the date of the **Accident** that caused the **Injury** and the date that the first medical service or treatment must be incurred for **Accident Medical Expense** Benefits to be payable under this **Policy**.

Medically Necessary means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care supervision or order.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary** for the care and treatment of the **Insured Person's Injury**. The term **Personal Comfort or Convenience Item(s)** includes, but is not limited to: (1) a private **Hospital** room, unless **Medically Necessary**; (2) television rental; and (3) **Hospital** telephone charges.

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

Usual and Customary Charge(s) means a charge that is made for a **Covered Accident Medical Expense** Benefit that: (1) does not include charges that would not have been made if no insurance existed; (2) is the lesser of the usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred, or the negotiated rate of the **Preferred Provider** designated by **Us**. For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit; and (3) with respect to drugs, is the negotiated rate of the **Preferred Provider** designated by **Us**, if applicable, or [[125%] of the Average Wholesale Price (AWP), if applicable] [[125%] of the generic drug price, if available] [[125%] of the Average Sales Price (ASP), if applicable].

SECTION V – LIMITATIONS

Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated in the **Schedule**.

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated in the **Schedule**.

Incarceration Limitation.

Benefits being made to an **Insured Person** will cease while the **Insured Person** is incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when the **Insured Person** is released from such facility.]

Pre-Existing Condition.

Benefits under this **Policy** for an **Injury** due to a **Pre-Existing Condition** will be limited to the amount shown in the **Schedule**.]

SECTION VI – GENERAL EXCLUSIONS

This **Policy** does not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** [, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation] or any **Injury** resulting from a provoked attack;
- illness or disease [,regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods];
- any **Pre-Existing Condition** [until the **Insured Person** has been continuously covered under this **Policy** for [twelve (12)] consecutive months];
- **Cumulative Trauma** and/or **Repetitive Conditions**, unless as shown in the **Schedule**;
- **Occupational Disease**[, unless (and to the extent as) specifically provided by this **Policy**];
- Hernia of any kind, unless as shown in the **Schedule**;
- Hemorrhoids of any kind;
- performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshore and Harbor Workers' Act, or similar coverage;
- war, or any act of war, whether declared or undeclared [unless it occurs in the following geographic locations [named countries]only];
- involvement in any type of active military service [.] [(Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31)] consecutive days.)] [(For purposes of this exclusion, orders to active military service for [sixty (60)] days or less will not be considered involvement in active military service.)][(This exclusion does not apply to the first [sixty (60)] consecutive days] of active military service.);
- any **Injury** for which the **Insured Person** is entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any loss insured by employers' liability insurance;
- the **Insured Person** being intoxicated. The **Insured Person** is conclusively deemed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle, when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured Person's** intoxication;
- [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance];][or][the use of a prescription drug unless taken as prescribed by a **Physician**];][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]
[the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions;]
- participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot];

- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the **Insured Person** is:
 - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft;
 - c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Insured Person**; [or]
- participation in any of the following activities:

skydiving	hang gliding	parachuting	parasailing
automobile racing or stunts	bungee-jumping	scuba diving	heli-skiing
motorcycle racing or stunts	endurance tests	fire fighting	racing
acrobatic or stunt flying	extreme sport stunts	[hunting]	

 flight on a rocket-propelled or rocket launched aircraft
 [or any other extra-hazardous activity]; or]
- [the use or release of [explosives, however delivered,] [nuclear energy,] [radiation,] [chemicals,] [biological agents or diseases,] [an organism or agent which disrupts the environmental or ecological balance of a geographic area] which results directly or indirectly from the intentional or unlawful act of a person or persons, including any resulting sickness or disease][.][; or]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**][.][; or]
- [alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.]

SECTION VII –TERMINATION OF POLICY

This **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:

1. the premium due date if premiums are not paid when due subject to the Grace Period;
2. the date specified in the written notice of **Our** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date **We** send such notice to the **Policyholder's** last known recorded address; or
3. the date specified in the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Policyholder** sends such notice to **Us**.

If **We** terminate this **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, **We** will return any unearned premium paid on a pro-rata basis.

Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

SECTION VIII – CLAIMS PROVISIONS

Notice. The **Insured Person** or the beneficiary, or someone on their behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must name the **Insured Person** and the **Policy** Number. To request a claim form, the **Insured Person** or the beneficiary, or someone on their behalf may contact **Us** at [1-111-111-1111]. The notice must be sent to the Claims Department at Atlantic Specialty Insurance Company, [44 Whippany Road, Morristown, NJ 07960], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include the **Insured Person's** name, the **Policyholder's** name and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which this **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible. and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which the **Insured Person** will make available to **Us** upon request.

Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, [within [thirty (30)] days] [immediately upon receipt] of written Proof of Loss that is acceptable to **Us**.

Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each [one (1)] week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. Loss of Life. **Covered Losses** resulting from the **Insured Person's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Insured Person**, **We** will pay the benefit to the **Insured Person's** survivors in the following order:
 - a. the **Insured Person's** legally married spouse;
 - b. the **Insured Person's** child(ren);
 - c. the **Insured Person's** parents;
 - d. the **Insured Person's** brothers and sisters;
 - e. the **Insured Person's** estate.
2. All Other Claims. Benefits are paid to the **Insured Person**. The **Insured Person** may direct in writing that all or part of an **Accident Medical Expense** Benefit be paid directly to the party who furnished the service. The direction may be changed by the **Insured Person** at any time up to the filing of the Proof of Loss. If an **Insured Person** dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary, or if there is no beneficiary designated, as set forth above.

Physical Examination and Autopsy. **We** have the right to examine an **Insured Person**, whose **Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If an **Insured Person** suffers a **Covered Loss(es)** as the result of **Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under this **Policy**. However, if the **Insured Person** receives payment from the third party, the **Insured Person** agrees to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If the **Insured Person** does not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of this **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Rehabilitation. **We** will consider a rehabilitation program for the **Insured Person** if he or she is receiving benefits under either the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit. The program must be mutually agreed upon by the **Insured Person** and **Us**. The extent of **Our** participation will be determined by mutual agreement and benefits payable will continue during the **Insured Person's** rehabilitation.

Sunset. In no event will a claim made for losses sustained by an **Insured Person** be considered valid and collectible in accordance with this **Policy** unless full details of such claim are presented to **Us** within three years from the date of the **Accident** which is the basis of such claim.

[Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under this **Policy** to the extent of the overpayment.]

[Suit Against Us. No action on this **Policy** may be brought until sixty (60) days after written Proof of Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Loss was required to be submitted. If the law of the state where the **Insured Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.]

[Mediation. Any contest to a claim denial under this **Policy** will be settled by non-binding mediation with **Our** consent and the consent of the **Insured Person** or beneficiary, whichever is applicable. The mediation will be administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules. The mediation will occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. No legal action may be brought by the **Insured Person**, beneficiary, or **Us** until thirty (30) days after the mediator(s) issues a non-binding award.]

[Recovery. In the event an **Insured Person** makes a recovery from a third party for a loss paid under this **Policy**, the **Insured Person** will reimburse **Us** up to the amount of the benefits made by **Us**.

[Subrogation. **We** have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to the **Insured Person** from anyone liable for the **Covered Injury**. If the **Insured Person** recovers from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to the **Insured Person**. The **Insured Person** agrees to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.]

[Claims for Workers' Compensation and Other Insurance. No benefits will be payable under this **Policy** for any loss which the **Insured Person** claims or files under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** will determine **Our** liability under the terms and conditions of this **Policy**. If such a claim is denied, and the **Insured Person** appeals the denial, no benefits will be paid under this **Policy** until a final disposition of the appeal is issued, at which time **We** will determine **Our** liability. **We** reserve the right to recover, from the **Insured Person**, any benefits paid under this **Policy** which are subsequently paid for under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If an **Insured Person** is determined by a court of law or the appropriate state regulatory authority to be covered under Workers' Compensation insurance for a **Covered Loss**, any benefits for which the **Insured Person** is eligible under this **Policy**, are payable to the person who was determined to be the **Insured Person's** employer or such person's designee or assignee. The Workers' Compensation exclusion in the GENERAL EXCLUSIONS Section of this **Policy** is deleted in its entirety.]

SECTION IX – GENERAL PROVISIONS

[Beneficiaries. The **Insured Person** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Insured Person** may change the beneficiary at any time. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs

[Change or Waiver. A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.

[Clerical Error. A clerical error or omission, whether by the **Policyholder**, the Producer, or **Us**, will not increase or continue an **Insured Person's** coverage, which otherwise would not be in force. If an **Insured Person** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity With Statute. Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Entire Contract. This **Policy**, together with any riders, endorsements, amendments, applications, completed enrollment materials and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

Insured Person Certificates. We will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Insured Persons**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insured Persons**. Such **Certificate** will contain a summary of terms that affect benefits.

Policyholder Records/Audit. The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured Person**. We may examine these records at reasonable times while the **Policy** is in force and for six (6) years after the termination of the **Policy**. We reserve the right to charge or refund premium, as applicable. The **Policyholder** will report to **Us**, within a reasonable time, all changes in information regarding an **Insured Person**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function. In addition, the **Policyholder** will be liable for any retroactive premium.]

Data Required. The **Policyholder** and the Producer must maintain adequate records acceptable to **Us** and provide any information required by **Us** relating to this insurance.

Renewal. This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.]

Assignment of Interest. This **Policy** is non-assignable.

Incontestability. The validity of this **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.]

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of this **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

Newly Acquired Subsidiary/Affiliated Company. If the **Policyholder** acquires a subsidiary or affiliated company that is to be covered under this **Policy**, and notifies **Us** of such acquisition within [thirty (30)] days of the date of acquisition, the eligible [**Owner-Operators**] and [**Contract Drivers**] of the **Newly Acquired Subsidiary/Affiliated Company** will be insured under this **Policy** as of the effective date of the acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, within the [thirty (30)] days, or does not pay such additional premium, if any, as required, the coverage for the [**Owner-Operators**] and [**Contract Drivers**] of the **Newly Acquired Subsidiary/Affiliated Company** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such coverage was in effect.]

Offset Debt. We will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from the **Policyholder** or the **Insured Person** to **Us** against any balance or balances, whether on account of losses or otherwise, due from **Us** to the **Policyholder** or the **Insured Person**.]

SECTION X – GENERAL DEFINITIONS

- **Accident or Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Accident Commencement Period** means the time period, shown in the **Schedule**, between the date of the **Accident**

which caused the **Injury** and the date the **Loss** must occur for death or dismemberment benefits to be payable under this **Policy**.

- **Actively At Work** means that the person is under **Dispatch** an average of [thirty (30)] hours each week.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in this **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- [Co-Driver means a person who drives in the same unit on a full-time basis with the **Primary Driver**.]
- **Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are payable under this **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. When the **Combined Single Limit** has been reached, no further benefits will be payable under this **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.
- **Contract Driver** is as described in SECTION I.
- **Co-Owner** means a person who has partial ownership of a vehicle operating as an **Owner-Operator**.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under this **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.
- **Cumulative Trauma** and/or **Repetitive Conditions** means conditions which impair the normal physiological function of the body over an extended period of time, and which do not arise as the result of a single **Accident**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Injuries** sustained by an **Insured Person** in a **Covered Accident**, which must be met before the **Accident Medical Expense** Benefit will be paid. The **Deductible Amount** is shown in the **Schedule**.
- **Dependent Child(ren)** means those unmarried children of the **Insured Person**, including natural children from the moment of birth, step or foster children, or adopted children, from the date of the final decree of adoption, [who rely on the **Insured Person** for [more than 50% of] their support [and are taken as dependents on the **Insured Person's** Federal Income Tax Return],] and who are either: 1) less than nineteen (19) years of age; or 2) less than twenty-three (23) years of age and enrolled on a full-time basis in a college, university or trade school, or who satisfy neither 1) nor 2), but who prior to age twenty-three (23), became incapable of self-sustaining employment by reason of mental retardation or physical handicap. **We** may require proof of such **Dependent Child(ren)'s** incapacity and dependency.
- **Dispatch** means when the **Insured Person** is:
 1. in route to pick up a load;
 2. picking up a load;
 3. in route to deliver a load;
 4. unloading a load;
 5. in route after dropping off a load;
 6. waiting for a load if the **Insured Person** is not at home;
 7. required to perform services by or for a motor carrier; or
 8. performing activities to comply with federal or state laws to satisfy motor carrier or commercial driving requirements.

Dispatch must be authorized by the **Policyholder**. **Dispatch** does not include an **Injury** during usual travel between, to, and from work or a bona fide leave of absence or vacation.

For purposes of this **Policy**, if the **Insured Person** is performing maintenance and/or repairs on a power unit which the **Insured Person** owns or leases, the **Insured Person** will be deemed to be under **Dispatch**. The **Insured Person** must provide proof which is satisfactory to **Us** that the **Injury** was sustained while performing such maintenance or repairs in order to receive **Occupational Accident Benefits** for the **Injury**.

- **Eligible Person** means a person who is described in the ELIGIBILITY portion of SECTION I.
- **Immediate Family Member** means a person who is related to the **Insured Person** in any of the following ways: **Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild) or any person residing in the **Insured Person's** home.
- **Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means a person who: (1) is an **Eligible Person** as described in the ELIGIBILITY portion of SECTION I; (2) has enrolled for coverage; and (3) has coverage in effect according to the terms of this **Policy**.
- **Mental and Nervous or Depressive Condition** means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.
- **Non-Occupational** means an activity involving an **Insured Person**, which occurs while the **Insured Person** is not under **Dispatch**. [If a **Co-Driver** is not operating a unit, any **Covered Injury** sustained will be considered a **Non-Occupational Covered Injury** and will be covered under the **Non-Occupational Accident** Benefit schedule.]
- **Occupational** means an activity involving an **Insured Person**, which occurs or arises out of or in the course of the **Insured Person** performing services while under **Dispatch**. **Occupational** does not encompass any period of time during the course of everyday travel to and from work or while on vacation.
- **Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.
- [**Occupational Cumulative Trauma** and/or **Repetitive Conditions** means bodily **Injury** to an **Insured Person** caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time, where: (1) such condition is diagnosed by a **Physician**; (2) the **Insured Person's** performance of the activities causing the **Injury** occurred during the **Policy** period, and the onset of the **Injury** occurred and was reported during the **Policy** period; and (3) such activities resulted directly and independently of all other causes in a **Covered Loss**.]
- **Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the **Insured Person's Occupational** activities, where: (1) such condition is diagnosed by a **Physician**, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; (2) exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which the **Insured Person** performs **Occupational** services; (3) the **Insured Person's** last day of last exposure to the environmental or physical hazards causing such condition occurs during the **Policy** Period; and (4) such exposure results directly and independently of all other causes in a **Covered Loss**.
- **Owner-Operator** is as described in SECTION I.
- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) the **Insured Person**; or (2) an **Immediate Family Member**; or (3) a practitioner retained by the **Policyholder**.
- **Policy** means this [Truckers] **Occupational Accident Insurance Policy**.
- **Policyholder** means the group named on the front page of this **Policy**.
- **Pre-Existing Condition** means a condition for which an **Insured Person** has sought or received medical advice or treatment during the twelve months immediately preceding his or her effective date of coverage under this **Policy**.
- **Preferred Provider** means a **Physician** or **Hospital** with which **We** have an agreement or contract to perform a covered service or treatment at an agreed upon rate or a company which provides prescription drugs at an agreed

upon rate to **Our Insured Persons**.

- **[Primary Driver** means a person who has ownership or leases a power unit and is the principal driver of the power unit.]
- **Principal Sum**, as applicable to each **Insured Person**, means the amount of insurance in force under this **Policy** as described in the **Schedule**.
- **Schedule** is SECTION II of this **Policy**.
- **Spouse** means the **Insured Person's** legally married spouse.
- **Waiting Period** means the consecutive number of days an **Insured Person** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit provisions of this **Policy**. **Benefits are not retroactive to the first day of disability**. The **Waiting Period** is shown in the **Schedule**.
- **We, Us, and Our** refers to Atlantic Specialty Insurance Company.

[Policyholder: **[ABC Company]**
Policy Number: **[123-456-789]**
Policy Effective Date: **[January 1, 2007]]**

[Underwritten by: **Atlantic Specialty Insurance Company]**



**OCCUPATIONAL ACCIDENT
CERTIFICATE OF INSURANCE**

**FOR
INDEPENDENT CONTRACTORS OF
[POLICYHOLDER]**

IMPORTANT NOTICE

THIS INSURANCE IS NOT WORKERS' COMPENSATION INSURANCE

IT IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION INSURANCE

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY

**IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR
LOSSES DUE TO SICKNESS**

**AND IT DOES NOT COVER ANY PERSON WHO IS REQUIRED TO BE COVERED BY A
WORKERS' COMPENSATION POLICY**

Atlantic Specialty Insurance Company
[1 Beacon Lane
Canton, MA 02021-1030]

POLICYHOLDER: [ABC Company]

POLICY NUMBER: [1234567]

**[COVERED SUBSIDIARIES OR
AFFILIATED COMPANIES** [Names of Companies]]

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

**OCCUPATIONAL ACCIDENT
CERTIFICATE OF INSURANCE**

Table of Contents

Provision	Section
Eligibility, Effective Date and Termination Date.....	I
Schedule of Benefits.....	II
Premium.....	III
Benefits.....	IV
Limitations.....	V
General Exclusions.....	VI
Claims Provisions.....	VII
General Provisions.....	VIII
General Definitions.....	IX

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY

You are eligible to become an **Insured Person** provided **You** [are [eighteen (18)] years of age, under **Dispatch** an average of [thirty (30)] hours each week (i.e. **Actively at Work**),] have completed enrollment material on file with the **Policyholder**, if required, and **You** are:

Class I:

[An **Actively at Work Owner-Operator** who is enrolled for coverage under the **Policy**. For purposes of the **Policy**, an **Owner-Operator** must lease to or from the **Policyholder** and must:

1. have a valid and current Commercial Driver's License;
2. own or lease a power unit;
3. be responsible for the maintenance of the power unit;
4. be responsible for the operating costs of the power unit, including but not limited to fuel, repairs, supplies and other expenses associated with the operation of the power unit;
5. be responsible for maintaining physical damage insurance on the power unit;
6. be responsible for hiring and supervising personnel who operate the power unit;
7. be compensated on a basis other than time expended in the performance of work;
8. be responsible for determining the route and hours for an assignment;
9. have the right to select the load;
10. have a written contract or assignment from the person who has engaged his or her services which provides that he or she is an independent contractor;
11. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose; [and]
12. [not be an employee of the **Policyholder**;] [and]
13. [receive a 1099 form for federal income tax reporting purposes, not a W-2.]

[Class II:]

[An **Actively at Work Contract Driver** who is enrolled for coverage under the **Policy**. For purposes of the **Policy**, a **Contract Driver** must:

1. have a valid and current Commercial Driver's License;
2. be authorized by an **Owner-Operator** or motor carrier to operate a power unit owned or leased by an **Owner-Operator**. (The **Contract Driver** must neither own nor lease the power unit.);
3. be compensated on a basis other than time expended in the performance of work;
4. be responsible for determining the route and hours for an assignment;
5. operate the power unit of the person who has engaged his or her services as an independent contractor. (Operating the unit must be the principal duty of the **Contract Driver**.)
6. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;
7. [receive a 1099 form for federal income tax reporting purposes, not a W-2;
8. [not be an employee of the **Policyholder**;]
9. [not be an employee of the **Owner-Operator**;] [and]
10. [not be an employee of the **Policyholder** or **Owner-Operator** unless it is not mandatory for workers' compensation coverage to be provided for such person as an employee of either the **Policyholder** or an **Owner-Operator**.]

[Class III:]

[As requested by the **Policyholder**]

You cannot be covered by any other **Occupational Accident Policy** issued by **Us**.

If **You** pay premium but are not eligible for coverage or do not qualify for benefits under the **Policy**, **We** will refund any premium paid in error.

YOUR COVERAGE EFFECTIVE DATE

Class I-[Owner-Operator]: [If **You** are an **[Owner-Operator]**, **Your** coverage under this **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above;
3. if an individual enrollment form is required, the date **Your** completed enrollment form is received by the **Policyholder** or an authorized person designated by the **Policyholder**.]

Class II-[Contract Driver]: [If **You** are a **[Contract Driver]**, **Your** coverage under this **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above;
3. if an individual enrollment form is required, the date **Your** completed enrollment form is received by the **Policyholder** or an authorized person designated by the **Policyholder**.]

Class III]-[as requested by Policyholder]: [as requested by **Policyholder**]

[**Your** coverage will not become effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of 1, 2 or 3 above. If premium is not paid when due, coverage will not be in effect.]

YOUR COVERAGE TERMINATION DATE

Class I-[Owner-Operator]: [If **You** are an **[Owner-Operator]**, **Your** coverage under this **Policy** ends on the earliest of:

1. the date this **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period;
3. the date **You** request, in writing, that **Your** coverage be terminated; or
4. the date **You** cease to be a member of an eligible Class as described above.]

Class II]-[Contract Driver]: [If **You** are a **[Contract Driver]**, **Your** coverage under this **Policy** ends on the earliest of:

1. the date this **Policy** is terminated;
2. the premium due date, if premiums are not paid when due, subject to the Grace Period;
3. the date **You** request, in writing, that **Your** coverage be terminated;
4. the date **You** cease to be a member of an eligible Class as described above; or
5. [the date the **[Owner-Operator]**, with respect to whom **You** are under contract, ceases to be a member of an eligible Class as described above.]]

Class III]-[as requested by Policyholder]: [as requested by **Policyholder**]

A change in **Your** coverage under this **Policy**, due to a change in **Your** eligible Class or benefit selection, becomes effective on the later of: (1) the date the change in **Your** eligible Class or benefit selection occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Covered Accidents** that occur after the change becomes effective.

Subject to the terms, conditions, exclusions and limitations of the **Policy**, termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while **Your** coverage was in force under this **Policy**.

SECTION II – SCHEDULE OF BENEFITS

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum *[\$50,000]
Accident Commencement Period..... [365 days]

Survivor's Benefit:

Principal Sum *[\$175,000]
[Monthly Benefit Percentage..... [1.0%]]
[Monthly Benefit Amount..... [\$1,750]]

Accidental Dismemberment Benefit:

Principal Sum * [\$225,000]
Accident Commencement Period..... [365 days]

Paralysis Benefit:

Principal Sum * [\$225,000]
Accident Commencement Period..... [365 days]

Temporary Total Disability Benefit:

Disability Commencement Period [90 days]
Waiting Period [7 days]
Benefit Percentage [66.67%]
Minimum Weekly Benefit Amount..... [\$125]
Maximum Weekly Benefit Amount..... [\$475]
Maximum Benefit Period ** [104 weeks]
[**Maximum Benefit Period** for Hernia..... [10 weeks]
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**
and/or **Repetitive Conditions** [10 weeks]]

Continuous Total Disability Benefit: ***

Waiting Period [Maximum Benefit Period for Temporary Total Disability]
Benefit Percentage [66.67%]
Minimum Weekly Benefit Amount..... [\$50]
Maximum Weekly Benefit Amount..... [\$475]
Maximum Benefit Amount..... [\$300,000]
Maximum Benefit Period..... [to age 70]

Accident Medical Expense Benefit:

Medical Commencement Period [90 days]
Deductible Amount..... [\$0]
Maximum Benefit Period..... [104 weeks]
Dental Maximum [\$1,000.00 per **Accident**]
Maximum Benefit Amount per Accident [\$750,000]
Lifetime Maximum Benefit [\$100,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy [[\$1,000] per **Injury**
[and] [a combined [36] visits]
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
Occupational Therapy, Work Hardening Therapy..... [\$1,000] per **Injury**
Ambulance [[one] round trip to and from a **Hospital**
[but] [not more than [\$1,000] for any one **Accident**]
[Air Ambulance] [[one] round trip to and from a **Hospital**
[but] [not more than [\$7,000] for any one **Accident**]]
[Hernia Coverage] lifetime **Maximum Benefit** of [\$10,000]]

Mental and Nervous – Outpatient [[\$25.00] per visit]
 [maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient [maximum [20] days]
 [maximum [\$1,000] for any one **Accident**]
[Occupational Cumulative Trauma and/or Repetitive Conditions]..... lifetime **Maximum Benefit** of [\$10,000]

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$750,000]
- **Aggregate Limit of Liability** [\$1,500,000]
 (applicable to all **Covered Losses** with respect to any one **Occupational Accident**)
- [Hernia Coverage..... combined lifetime **Maximum Benefit** of [\$15,000]]
- **[Occupational Cumulative Trauma and/or Repetitive Conditions]**
 combined lifetime **Maximum Benefit** of [\$15,000]]
- **[Pre-Existing Condition Limitation** [\$10,000]]

*At age [65], **Your Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	[80%]
66	[60%]
67	[40%]
68	[20%]
69	[15%]
[70 and over]	[10%]

** If **You** sustain a **Covered Injury** at or after age [70], the **Maximum Benefit Period** will be [one (1) year].

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum * [\$7,500]
Accident Commencement Period..... [365 days]

Accidental Dismemberment Benefit:

Principal Sum * [\$7,500]
Accident Commencement Period..... [365 days]

Accident Medical Expense Benefit:

Medical Commencement Period [90 days]
Deductible Amount [\$0]
Maximum Benefit Period..... [52 weeks]
 Dental Maximum [\$1,000 per **Accident**]
Maximum Benefit Amount per Accident..... [\$5,000]
Lifetime Maximum Benefit [\$10,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy..... [[\$1,000] per **Injury**
 [and][a combined [36] visits]
 Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
 Occupational Therapy, Work Hardening Therapy [\$1,000] per **Injury**
 Ambulance [[one] round trip to and from a **Hospital**
 [but][not more than [\$1,000] for any one **Accident**]
 [Air Ambulance] [[one] round trip to and from a **Hospital**
 [but][not more than [\$7,000] for any one **Accident**]
Mental and Nervous – Outpatient [[\$25.00] per visit]
 [maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient [maximum [20] days]
 [maximum [\$1,000] for any one **Accident**]

NON-OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$7,500]
- **Aggregate Limit of Liability**..... [\$15,000]
 (applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

* At age [65], **Your Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	[80%]
66	[60%]
67	[40%]
68	[20%]
69	[15%]
[70 and over]	[10%]

SECTION III – PREMIUM

Premium Due Date: 1st of each month]

Premium Amount:

Class I: \$[0.00] per [Owner-Operator] per month
[Class II:] [\$[0.00] per [Contract Driver] per month]
[Class III:] [\$[0.00] per [as requested by Policyholder] per month]

If **You** enroll on or prior to the fifteenth of the month, **You** will pay an amount equal to the full monthly premium. No premium will be payable for the last full or partial month of coverage.

If **You** enroll after the fifteenth of the month, **You** will pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** will pay an amount equal to the monthly premium.]

Grace Period:

A Grace Period of [thirty (30)] days will be provided for the payment of any premium due after the first premium. Your coverage will not be terminated for nonpayment of premium during the Grace Period if **You** pay the premiums due by the last day of the Grace Period. **Your** coverage will terminate if all premiums due are not paid by the last day of the Grace Period.

No Grace Period will be provided if **We** receive notice to terminate **Your** coverage prior to a premium due date.]

Waiver of Premium:

Subject to the **Policy** remaining in force, all premiums due under the **Policy** with respect to **You** receiving either a **Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit under the **Policy** will be waived. Premiums will be waived from the first premium due date on or after the date the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit begins. Premium payments must be resumed on the premium due date next following the date **Your Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit ceases. If premium payments are not resumed on that date, **Your** coverage under this **Policy** will end on that date. **You** are responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or **Us**.

SECTION IV – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Injury** to **You** results in death within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the **Principal Sum** shown in the **Schedule**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If **You** suffer an **Accidental** Death such that an **Accidental** Death Benefit is payable under this **Policy**, **We** will pay **Your** beneficiary in accordance with the Payment of Claims provision.

Survivor's Benefit

The Monthly Benefit Amount will be as described in the **Schedule**. The Monthly Benefit Amount will be paid to **Your** surviving **Spouse** up to the **Principal Sum** shown in the **Schedule**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your last Dependent Child** dies or is no longer eligible as defined in the GENERAL DEFINITIONS Section of the **Policy**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will pay only the **Accidental** Death Benefit in accordance with the Payment of Claims provision of the **Policy**. **We** will not pay a Survivor's Benefit.

Exposure and Disappearance

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If **Your** body has not been found within 365 days after the disappearance, stranding, sinking or wrecking of a [power unit] in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered **Accidental** Death within the meaning of the **Policy**. If **You** are subsequently found alive and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to **You** results in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

<u>For Covered Loss of:</u>	<u>Percentage of the Principal Sum</u>
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]

For purposes of the **Accidental** Dismemberment Benefit, **Loss** will mean:

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one **Loss** is sustained by an **Insured Person** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

PARALYSIS BENEFIT (does not apply to a **Non-Occupational Accident**)

If a **Covered Injury** to **You** results in any Type of Paralysis specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

<u>Type of Paralysis:</u>	<u>Percentage of the Principal Sum</u>
Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**. **Paraplegia** means the complete and irreversible paralysis of both lower **Limbs**. **Hemiplegia** means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body. **Uniplegia** means the complete and irreversible paralysis of one **Limb**. For purposes of this benefit **Limb** means entire arm or entire leg.

If **You** sustain more than one Type of Paralysis as a result of the same **Covered Accident**, only the largest single amount will be considered a **Covered Loss**.

TEMPORARY TOTAL DISABILITY (TTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

TTD Benefit Qualifications.

If a **Covered Injury** to **You Person** results in **Temporary Total Disability** within the **Disability Commencement Period** shown in the **Schedule**, **We** will pay the **Temporary Total Disability** Benefit specified below, subject to satisfaction of any applicable **Waiting Period** shown in the **Schedule**. **The Disability Commencement Period** starts on the date of the **Accident** that caused such **Injury**. After the **Waiting Period** has been satisfied, the **Temporary Total Disability** Benefit will be payable from the day the **Waiting Period** was satisfied.

TTD Benefit Amount.

The **Temporary Total Disability** Benefit with respect to each week of **Your Temporary Total Disability** during a **Single Period of Total Disability** is equal to the lesser of:

1. the Benefit Percentage (as shown in the **Schedule**) of **Your Average Weekly Earnings**; or
2. the **Maximum Weekly Benefit Amount** shown in the **Schedule**.

In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Temporary Total Disability** Benefit with respect to less than a full **Benefit Week** of **Temporary Total Disability** equals 1/7th of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

TTD Benefit Calculation.

For the purposes of this **Temporary Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- If **You** are a Class I [**Owner-Operators**]:
[[Thirty-three percent (33%)] of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than [fifty (50)] weeks during the prior year, then [thirty-three percent (33%)] of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than [fifty (50)] weeks.]
- [If **You** are a Class II] [**Contract Drivers**]:
[[Seventy-five percent (75%)] of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than [fifty (50)] weeks during the prior year, then [seventy-five percent (75%)] of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than [fifty (50)] weeks.]

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

TTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** Disability; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

TTD Benefit Termination.

The **Temporary Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date the **Maximum Benefit Period** shown in the **Schedule** has been reached;
3. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to Us; or
4. the date **You** die.

TTD Benefit Definitions.

As used in this **Temporary Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the first day of **Temporary Total Disability** after the **Waiting Period** shown in the **Schedule** for **Temporary Total Disability**, and on the same day of each week thereafter.

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

Disability Commencement Period means the time period, shown in the **Schedule**, between the date of the **Accident** that caused the **Injury** and the date that **Temporary Total Disability** must begin for disability benefits to be payable under this **Policy**.

Maximum Benefit Period means, with respect to **Temporary Total Disability**, the maximum period for which benefits will be payable for a **Temporary Total Disability Covered Loss** during a **Single Period of Total Disability**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Temporary Total Disability** is shown in the **Schedule**.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following which are considered separate periods of disability: (1) successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which the **You** are not **Temporarily Totally Disabled**; (2) successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least 6 months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or **Temporarily Totally Disabled** means disability that: (1) prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation [as a commercial truck driver]; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for the **Temporary Total Disability** Benefit.

[For purposes of this section "**Material and Substantial Duties**" will mean a duty or duties which **You** are required to perform as an [Owner-Operator] [or] [Contract Driver].]

CONTINUOUS TOTAL DISABILITY (CTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

CTD Benefit Qualifications.

If a **Covered Injury** to **You** resulting in **Temporary Total Disability**, subsequently results in **Continuous Total Disability**, We will pay the **Continuous Total Disability** Benefit specified below, provided:

1. the benefits payable for the **Temporary Total Disability Covered Loss** ceased solely because the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached, but **You** remain disabled;
2. **You** are under the normal Social Security retirement age, as determined by federal law, on the day after the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached;
3. **You** have been granted a Social Security Disability Award for **Your** disability (If **You** cannot meet the credit requirement for a Social Security Award, **You** cannot qualify for the **Continuous Total Disability** Benefit even if **You** would otherwise qualify);
4. **Your** disability is reasonably expected to continue without interruption until **You** die, and is substantiated by objective medical evidence satisfactory to Us;

5. the **Injury** began within the **Disability Commencement Period** shown in the **Schedule**.; and]
6. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**. (If the **Temporary Total Disability** was principally due to a **Mental and Nervous or Depressive Condition**, **You** do not qualify for a **Continuous Total Disability** Benefit.)]

You cannot qualify for a **Continuous Total Disability** Benefit unless **You** qualified for a **Temporary Total Disability** Benefit for the same **Covered Injury**.

Sunset Period: If **You** are not granted a Social Security Award for **Your** disability within two (2) years of the **Injury**, **You** cannot qualify for a **Continuous Total Disability** Benefit even if **You** would otherwise qualify.

CTD Benefit Amount.

The **Weekly Benefit Amount** will be the lesser of the benefit percentage, as shown in the **Schedule**, of **Your Average Weekly Earnings**, or the **Maximum Weekly Benefit Amount** as shown in the **Schedule**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Continuous Total Disability** Benefit with respect to less than a full **Benefit Week** of **Continuous Total Disability** equals 1/7th of the **Weekly Benefit** for each day of **Continuous Total Disability**.

CTD Benefit Calculation.

For purposes of this **Continuous Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- If **You** are a Class I [**Owner-Operator**]:
[[Thirty-three percent (33%)] of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than [fifty (50)] weeks during the prior year, then [thirty-three percent (33%)] of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than [fifty (50) weeks].]
- [If **You** are a Class II] [**Contract Driver**]:
[[Seventy-five percent (75%)] of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than [fifty (50)] weeks during the prior year, then [seventy-five percent (75%)] of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than [fifty (50) weeks].]

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as [an **Owner-Operator**] or [**Contract Driver**] for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

CTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your Disability**; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CTD Benefit Termination.

The **Continuous Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **Your** Social Security Disability Award ceases;
3. the date **You** attain age [70];

4. the date the **Maximum Benefit Period** shown in the **Schedule** for **Continuous Total Disability** has been reached;
5. the date the **Maximum Benefit Amount** shown in the **Schedule** for **Continuous Total Disability** has been reached;
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to Us; or
7. the date **You** die.

CTD Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Benefit Week means a 7-day period of time that begins on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Care means at least quarterly monitoring and/or evaluation of the disabling condition by a **Physician**. We must receive proof of continuing **Continuous Total Disability** on a quarterly basis. These requirements may be waived by Us.

Continuous Total Disability or **Continuously Totally Disabled** means disability that: (1) prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for a **Continuous Total Disability** Benefit.

If **You** can perform an occupation which would provide an annual gross income equal to or greater than either the gross income from wages and/or the net income reported on Schedule C which **You** filed on **Your** most recent federal income tax return filed prior to the **Covered Injury**, **You** are not **Continuously Totally Disabled**. **You** must provide Us with such federal income tax return in order to qualify for a **Continuous Total Disability** Benefit.

Maximum Benefit Amount means, with respect to **Continuous Total Disability**, the maximum benefits payable for **Continuous Total Disability Covered Losses**.

Maximum Benefit Period means, with respect to **Continuous Total Disability**, the maximum period for which benefits will be payable for a **Continuous Total Disability Covered Loss**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Continuous Total Disability** is shown in the **Schedule**. Benefits payable under the **Temporary Total Disability** Benefit will not be considered **Continuous Total Disability** Benefits for purposes of applying the **Maximum Benefit Period**.

Terms used in this **Continuous Total Disability** Benefit, but which refer to **Temporary Total Disability** and are defined in the **Temporary Total Disability** Benefit, are to be interpreted as defined in that Benefit.

ACCIDENT MEDICAL EXPENSE (AME) BENEFIT

AME Benefit Qualifications.

If **You** suffer an **Injury** that requires **You** to be treated by a **Physician**, within the **Medical Commencement Period** shown in the **Schedule**, We will pay the **Usual and Customary Charges** incurred for **Medically Necessary Covered Accident Medical Services** received due to that **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown in the **Schedule**, for **You**, for all **Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Injury**. The **Deductible Amount** for the **Accident Medical Expense** Benefit is the **Deductible Amount** shown in the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Injuries** **You** sustained in that **Covered Accident**. [If the **Injury** is related to a **Pre-Existing Condition**, the **Accident Medical Expense** Benefit will be subject to the limit as shown in the **Schedule**.]

AME Benefit Covered Accident Medical Services.

1. **Hospital** semi-private room and board (or room and board in an intensive care unit), **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;

2. Services of a **Physician** or a qualified nurse, if under the supervision of a Graduate Registered Nurse (RN), for **Home Health Care** which follows a [five (5)] day period of **Hospital** confinement and which is prescribed by a **Physician**;
3. Services by a qualified **Physician** for the treatment of a covered **Mental and Nervous Condition** due to a **Covered Injury**. However, such charges will be considered a **Covered Accident Medical Expense** only to the extent that the charges do not exceed [\$25.00] per visit and are further limited to one visit per day with a maximum of [twenty (20)] visits. **Hospital** charges for in-patient treatment of a **Mental and Nervous Condition**, whether in a psychiatric **Hospital** or a general **Hospital**, will be considered a **Covered Accident Medical Expense** and will be limited to up to a [twenty (20)] day inpatient maximum;
4. Ambulance, including air ambulance, service to or from a **Hospital** for [one] round trip;
5. Laboratory tests;
6. Radiological procedures;
7. Anesthetics and the administration of anesthetics;
8. Blood, blood products and artificial blood products, and the transfusion thereof;
9. Physical Therapy, Occupational Therapy, Work Hardening Therapy and Chiropractic or Acupuncturist Care as shown in the **Schedule**;
10. Rental of **Durable Medical Equipment**, up to the actual purchase price of such equipment;
11. The initial supply, but not replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes subject to the **Accident Medical Expense Benefit Exclusions** section;
12. Medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
13. Repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the Dental Maximum, if any, shown in the **Schedule**.
14. **Extended Care Facilities**; or
15. **Home Health Care**.

The foregoing **Covered Accident Medical Services** are subject to all of the limits as shown in the **Schedule**.

AME Benefit Exclusions.

In addition to the GENERAL EXCLUSIONS in SECTION VI of the **Policy**, charges for **Covered Accident Medical Services** do not include, and benefits are not payable with respect to, any expense for or resulting from:

- repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
- dentures, bridges, dental implants, or treatment not related to the **Injury**;
- eye glasses or contact lenses;
- hearing aids or hearing examinations;
- that portion of rental expense for **Durable Medical Equipment** that exceeds the usual purchase cost for similar equipment in the locality where the expense is incurred;
- **Custodial Services**;
- **Personal Comfort or Convenience Items**;
- services of a Federal, Veteran's, State or Municipal **Hospital** for which **You** are not liable for payment;
- services or treatment which is covered by Medicare;
- that portion of the fee for services or treatment which is more than the **Usual and Customary Charge**;
- cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of an **Injury**;
- services or treatment which are provided for in a settlement or court judgment;
- services or treatment which are covered under any other insurance of any kind;
- services or treatment for which **You** are not legally obligated to pay;
- an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
- any mileage charges related to the **Covered Injury** unless authorized by **Us**;

- any translation charges related to the **Covered Injury** unless authorized by **Us**; or
- any lodging charges related to the **Covered Injury** unless authorized by **Us**.

AME Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Ambulatory Medical Center means a facility that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.

Custodial Services means any services which are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services: (1) related to watching or protecting **You**; (2) related to performing or assisting **You** in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and (3) that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Extended Care Facility means an institution that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. is approved by the Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a Graduate Registered Nurse (RN);
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment for **You** in **Your** home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:

1. be approved in writing by the attending **Physician**;
2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
3. begin within [seven (7)] days after discharge from a **Hospital**; and
4. follow a **Hospital** confinement of [five (5)] days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of **Your** immediate family; or
2. a person residing in **Your** home.

Hospital means a facility that: (1) operates under the law of the state that it is situated in; (2) is approved by the Department of Health and Human Services or its successor; (3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and (5) is supervised by one or more **Physicians**. A **Hospital** does not include: (1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or (3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Maximum Benefit Period means, with respect to the **Accident Medical Expense** Benefit, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The length of the **Maximum Benefit Period** for **Accident Medical Expense** is shown in the **Schedule**.

Medical Commencement Period means the time period shown in the **Schedule** between the date of the **Accident** that caused the **Injury** and the date that the first medical service or treatment must be incurred for **Accident Medical Expense** Benefits to be payable under this **Policy**.

Medically Necessary means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care supervision or order.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary** for the care and treatment of **Your Injury**. The term **Personal Comfort or Convenience Item(s)** includes, but is not limited to: (1) a private **Hospital** room, unless **Medically Necessary**; (2) television rental; and (3) **Hospital** telephone charges.

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

Usual and Customary Charge(s) means a charge that is made for a **Covered Accident Medical Expense** Benefit that: (1) does not include charges that would not have been made if no insurance existed; (2) is the lesser of the usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred, or the negotiated rate of the **Preferred Provider** designated by **Us**. For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit; and (3) with respect to drugs, is the negotiated rate of the **Preferred Provider** designated by **Us**, if applicable, or [[125%] of the Average Wholesale Price (AWP), if applicable] [[125%] of the generic drug price, if available] [[125%] of the Average Sales Price (ASP), if applicable].

SECTION V – LIMITATIONS

Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated in the **Schedule**.

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated in the **Schedule**.

[Incarceration Limitation.

Benefits being made to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.]

[Pre-Existing Condition.

Benefits under the **Policy** for an **Injury** due to a **Pre-Existing Condition** will be limited to the amount shown in the **Schedule**.]

SECTION VI – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused in whole or in part by, or results in whole or in part from:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** [, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation] or any **Injury** resulting from a provoked attack;
- illness or disease [,regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods];
- any **Pre-Existing Condition** [until **You** have been continuously covered under this **Policy** for [twelve (12)] consecutive months];
- **Cumulative Trauma** and/or **Repetitive Conditions**, unless as shown in the **Schedule**;
- **Occupational Disease**[, unless (and to the extent as) specifically provided by this **Policy**];
- Hernia of any kind, unless as shown in the **Schedule**;
- Hemorrhoids of any kind;
- performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;
- war, or any act of war, whether declared or undeclared [unless it occurs in the following geographic locations [named countries]only];
- involvement in any type of active military service [.] [(Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31)] consecutive days.)] [(For purposes of this exclusion, orders to active military service for [sixty (60)] days or less will not be considered involvement in active military service.)][(This exclusion does not apply to the first [sixty (60)] consecutive days of active military service.)];
- any **Injury** for which **You** are entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any loss insured by employers' liability insurance;
- **You** being intoxicated. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle, when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication;
- [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance];][or][the use of a prescription drug unless taken as prescribed by a **Physician**];][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];
[the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions;]
- participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot];
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
 - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft;
 - c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or an **Insured Person**; [or]
- participation in any of the following activities:

skydiving	hang gliding	parachuting	parasailing
automobile racing or stunts	bungee-jumping	scuba diving	heli-skiing

motorcycle racing or stunts endurance tests fire fighting racing
acrobatic or stunt flying extreme sport stunts [hunting]
flight on a rocket-propelled or rocket launched aircraft
[or any other extra-hazardous activity]; or]

- [the use or release of [explosives, however delivered,] [nuclear energy,] [radiation,] [chemicals,] [biological agents or diseases,] [an organism or agent which disrupts the environmental or ecological balance of a geographic area] which results directly or indirectly from the intentional or unlawful act of a person or persons, including any resulting sickness or disease][.][; or]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**][.][; or]
- [alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.]

SECTION VII – CLAIMS PROVISIONS

Notice. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must include **Your** name and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at [1-111-111-1111]. The notice must be sent to the Claims Department at Atlantic Specialty Insurance Company, [44 Whippany Road, Morristown, NJ 07960], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include **Your** name, the **Policyholder's** name and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible. and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which **You** will make available to **Us** upon request.

Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, [within [thirty (30)] days] [immediately upon receipt] of written Proof of Loss that is acceptable to **Us**.

Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each [one (1)] week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your** legally married spouse;
 - b. **Your** child(ren);
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
2. All Other Claims. Benefits are paid to **You**. **You** may direct in writing that all or part of an **Accident Medical Expense** Benefit be paid directly to the party who furnished the service. **You** may change the direction at any time up to the

filing of the Proof of Loss. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary, or if there is no beneficiary designated, as set forth above.

Physical Examination and Autopsy. We have the right to examine **You** if **Your Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If **You** suffer a **Covered Loss(es)** as the result of **Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You** receive payment from the third party, **You** agree to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If **You** do not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Rehabilitation. We will consider a rehabilitation program for **You** if **You** are receiving benefits under either the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit. The program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined by mutual agreement and benefits payable will continue during **Your** rehabilitation.

Sunset. In no event will a claim made for losses **You** sustained be considered valid and collectible in accordance with the **Policy** unless full details of such claim are presented to **Us** within three (3) years from the date of the **Accident** which is the basis of such claim.

[Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.]

[Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Loss was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.]

[Mediation. Any contest to a claim denial under the **Policy** will be settled by non-binding mediation with **Our** consent and **Your** consent or the consent of **Your** beneficiary, whichever is applicable. The mediation will be administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules. The mediation will occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be **Your** beneficiary. No legal action may be brought by **You**, **Your** beneficiary, or **Us** until thirty (30) days after the mediator(s) issues a non-binding award.]

Recovery. In the event **You** make a recovery from a third party for a loss paid under the **Policy**, **You** will reimburse **Us** up to the amount of the benefits made by **Us**.

[Subrogation. We have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to **You** from anyone liable for the **Covered Injury**. If **You** recover from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**. **You** agree to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.]

[Claims for Workers' Compensation and Other Insurance. No benefits will be payable under the **Policy** for any loss which **You** claim or file under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** will determine **Our**

liability under the terms and conditions of the **Policy**. If such a claim is denied, **You** appeal the denial, no benefits will be paid under the **Policy** until a final disposition of the appeal is issued, at which time **We** will determine **Our** liability. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** which are subsequently paid for under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If **You** are determined by a court of law or the appropriate state regulatory authority to be covered under Workers' Compensation insurance for a **Covered Loss**, any benefits for which **You** are eligible under the **Policy**, are payable to the person who was determined to be **Your** employer or such person's designee or assignee. The Workers' Compensation exclusion in the GENERAL EXCLUSIONS Section of the **Policy** is deleted in its entirety.]

SECTION VIII – GENERAL PROVISIONS

Beneficiaries. **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission, whether by the **Policyholder**, the Producer, or **Us**, will not increase or continue **Your** coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity With Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Assignment of Interest. The **Policy** is non-assignable.

[Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.]

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

[Offset Debt. **We** will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from **You** to **Us** against any balance or balances, whether on account of losses or otherwise, due from **Us** to **You**.]

SECTION IX – GENERAL DEFINITIONS

- **Accident or Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Accident Commencement Period** means the time period, shown in the **Schedule**, between the date of the **Accident**

which caused the **Injury** and the date the **Loss** must occur for death or dismemberment benefits to be payable under this **Policy**.

- **Actively At Work** means that **You** are under **Dispatch** an average of [thirty (30)] hours each week.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- [Co-Driver means a person who drives in the same unit on a full-time basis with the **Primary Driver**.]
- **Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are payable under the **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. When the **Combined Single Limit** has been reached, no further benefits will be payable under the **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.
- **Contract Driver** is as described in SECTION I.
- **Co-Owner** means a person who has partial ownership of a vehicle operating as an **Owner-Operator**.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while **You** are insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Cumulative Trauma** and/or **Repetitive Conditions** means conditions which impair the normal physiological function of the body over an extended period of time, and which do not arise as the result of a single **Accident**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Injuries You** sustain in a **Covered Accident**, which must be met before the **Accident Medical Expense** Benefit will be paid. The **Deductible Amount** is shown in the **Schedule**.
- **Dependent Child(ren)** means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children, from the date of the final decree of adoption, [who rely on **You** for [more than 50% of] their support [and are taken as dependents on **Your** Federal Income Tax Return],] and who are either: 1) less than nineteen (19) years of age; or 2) less than twenty-three (23) years of age and enrolled on a full-time basis in a college, university or trade school, or who satisfy neither 1) nor 2), but who prior to age twenty-three (23), became incapable of self-sustaining employment by reason of mental retardation or physical handicap. **We** may require proof of such **Dependent Child(ren)**'s incapacity and dependency.
- **Dispatch** means when **You** are:
 1. in route to pick up a load;
 2. picking up a load;
 3. in route to deliver a load;
 4. unloading a load;
 5. in route after dropping off a load;
 6. waiting for a load if **You** are not at home;
 7. required to perform services by or for a motor carrier; or
 8. performing activities to comply with federal or state laws to satisfy motor carrier or commercial driving requirements.

Dispatch must be authorized by the **Policyholder**. **Dispatch** does not include an **Injury** during usual travel between, to, and from work or a bona fide leave of absence or vacation.

For purposes of the **Policy**, if **You** are performing maintenance and/or repairs on a power unit which **You** own or lease, **You** will be deemed to be under **Dispatch**. **You** must provide proof which is satisfactory to **Us** that the **Injury** was sustained while performing such maintenance or repairs in order to receive **Occupational Accident Benefits** for the **Injury**.

- **Eligible Person** means a person who is described in the ELIGIBILITY portion of SECTION I.
- **Immediate Family Member** means a person who is related to **You** in any of the following ways: **Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild) or any person residing in **Your** home.
- **Injury** or **Injuries** means bodily harm or bodily damage.
- **Insured Person** means a person who: (1) is an **Eligible Person** as described in the ELIGIBILITY portion of SECTION I; (2) has enrolled for coverage; and (3) has coverage in effect according to the terms of the **Policy**.
- **Mental and Nervous** or **Depressive Condition** means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.
- **Non-Occupational** means an activity involving **You**, which occurs while **You** are not under **Dispatch**. [If a **Co-Driver** is not operating a unit, any **Covered Injury** sustained will be considered a **Non-Occupational Covered Injury** and will be covered under the **Non-Occupational Accident** Benefit schedule.]
- **Occupational** means an activity involving **You**, which occurs or arises out of or in the course of **You** performing services while under **Dispatch**. **Occupational** does not encompass any period of time during the course of everyday travel to and from work or while on vacation.
- **Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.
- [Occupational Cumulative Trauma and/or Repetitive Conditions means bodily **Injury** to **You** caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time, where: (1) such condition is diagnosed by a **Physician**; (2) **Your** performance of the activities causing the **Injury** occurred during the **Policy** period, and the onset of the **Injury** occurred and was reported during the **Policy** period; and (3) such activities resulted directly and independently of all other causes in a **Covered Loss**.]
- **Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, where: (1) such condition is diagnosed by a **Physician**, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; (2) exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** services; (3) **Your** last day of last exposure to the environmental or physical hazards causing such condition occurs during the **Policy** period; and (4) such exposure results directly and independently of all other causes in a **Covered Loss**.
- **Owner-Operator** is as described in SECTION I.
- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) **You**; or (2) **Your Immediate Family Member**; or (3) a practitioner retained by the **Policyholder**.
- **Policy** means the [Truckers] **Occupational Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Pre-Existing Condition** means a condition for which **You** have sought or received medical advice or treatment during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.

- **Preferred Provider** means a **Physician** or **Hospital** with which **We** have an agreement or contract to perform a covered service or treatment at an agreed upon rate or a company which provides prescription drugs at an agreed upon rate to **You**.
- [**Primary Driver** means a person who has ownership or leases a power unit and is the principal driver of the power unit.]
- **Principal Sum**, as applicable to **You**, means the amount of insurance in force under the **Policy** as described in the **Schedule**.
- **Schedule** is SECTION II of this Certificate.
- **Spouse** means **Your** legally married spouse.
- **Waiting Period** means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit provisions of the **Policy**. **Benefits are not retroactive to the first day of disability**. The **Waiting Period** is shown in the **Schedule**.
- **We, Us, and Our** refers to Atlantic Specialty Insurance Company.
- **You** and **Your** refers to the **Insured Person**

In Witness Whereof, We have caused the Policy to be executed and attested.



Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company



Michael Miller, President & CEO
Atlantic Specialty Insurance Company



Policyholder: [ABC Company]

Effective Date of Endorsement: [January 1, 2007]

Policy Number: [1234567]

ADMINISTRATIVE CHANGE ENDORSEMENT

[This endorsement will be used to make the following changes to the **Policy**:

Addition or deletion of a subsidiary or affiliate

Name change of **Policyholder**

Address change of **Policyholder**

Changes to the Eligibility or Schedule pages, e.g. change to the classes of Insured Persons or increasing or decreasing amounts of coverage

Renewal

Other administrative changes]

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller

Michael Miller, President & CEO
Atlantic Specialty Insurance Company



POLICYHOLDER APPLICATION
TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

POLICYHOLDER INFORMATION

Motor Carrier Name: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Contact Person: _____ Title: _____
 Telephone Number: _____ Fax Number: _____
 USDOT Number: _____

Please answer the following questions:

- Number of years in business: _____
- Is there Occupational Accident coverage in force now? Yes* _____ No _____
 If yes, who is the carrier? _____
Please supply copy of the policy.
 What is the in force rate? \$ _____
- Number of Independent Contract Drivers to be covered: _____
Please provide copy of the most current drivers list.
- Average annual miles per driver: _____
- Radius of operations:

0-50 miles	_____ %
50-200miles	_____ %
200+miles	_____ %
Maximum length of haul	_____ miles
- What do drivers haul? _____
- Percentage of equipment:

Box	_____ %
Flatbeds	_____ %
Tankers	_____ %
Refrigerated	_____ %
Container	_____ %
Dump	_____ %
Other (describe) _____	_____ %
- Do the drivers load or unload? Yes _____ No _____
 If yes, what percentage of time? _____ %
- Is the driver responsible for maintenance of the truck? Yes _____ No _____
- How are the drivers compensated? ** _____
- Do you have employee drivers? Yes _____ No _____
 If yes, how many? _____

- Do drivers sign Owner-Operator Lease Agreements? Yes _____ No _____
If yes, please supply a copy of the Lease Agreement.
- Do you lease Contract Drivers from fleet operations? Yes _____ No _____
 If yes, how many? _____
- Do you require that the Contract Drivers submit an application or enrollment form to you? Yes _____ No _____
- Do you lease out drivers to other motor carriers? Yes _____ No _____
 If yes, to whom and how many? _____
- Will Occupational Accident coverage be: voluntary _____ or compulsory _____
- Are Casual Laborers or Helpers used? Yes _____ No _____
 If yes, where and how? _____
- Do you provide light or restricted duty for drivers? Yes _____ No _____
 If yes, describe: _____
- Terminal locations (attach list if needed): _____
- Indicate number of Owner-Operators by state of residence:

_____ Alabama	_____ Louisiana	_____ Oklahoma
_____ Alaska	_____ Maine	_____ Oregon
_____ Arizona	_____ Maryland	_____ Pennsylvania
_____ Arkansas	_____ Massachusetts	_____ Puerto Rico
_____ California	_____ Michigan	_____ Rhode Island
_____ Colorado	_____ Minnesota	_____ South Carolina
_____ Connecticut	_____ Mississippi	_____ South Dakota
_____ Delaware	_____ Missouri	_____ Tennessee
_____ District of Columbia	_____ Montana	_____ Texas
_____ Florida	_____ Nebraska	_____ Utah
_____ Georgia	_____ Nevada	_____ Vermont
_____ Hawaii	_____ New Hampshire	_____ Virginia
_____ Idaho	_____ New Jersey	_____ Washington
_____ Illinois	_____ New Mexico	_____ West Virginia
_____ Indiana	_____ New York	_____ Wisconsin
_____ Iowa	_____ North Carolina	_____ Wyoming
_____ Kansas	_____ North Dakota	
_____ Kentucky	_____ Ohio	_____ TOTAL
- Provide details of minimum standards for Owner-Operators:
 - Minimum age: _____
 - Maximum age: _____
 - Minimum prior experience as an Owner-Operator: _____
 - Minimum prior experience driving similar equipment: _____
 - Maximum number of accidents permitted: # _____ in past _____ years
 - Maximum number of violations permitted: # _____ in past _____ years
 - Do you provide training for the Owner-Operator? Yes _____ No _____
 - Describe any other criteria for qualifying Owner-Operators:

- Has an Owner-Operator or Contract Driver filed a Workers' Compensation claim in the past three (3) years? Yes _____ No _____
 If yes, what was the disposition of such claim(s)? _____

- Provide information about Safety and Loss Control:

Name of safety manager: _____

Number of years experience in loss prevention: _____

Number of years working with you: _____

Provide details of in force safety program:

- Please indicate the situs state where the **Policyholder's** contract is to be issued: _____

* **Experience: Please provide:** (1) the last three (3) years of Occupational Accident coverage loss runs. The losses should present detailed medical and indemnity claims both reserved and paid. and (2) a complete description of injury and circumstances of any loss to an Owner-Operator involving death, dismemberment, or TTD/CTD losses in excess of \$25,000.

** **Please provide a copy of the standard settlement statement provided to the drivers.**

PRODUCER INFORMATION

Agent/Broker: _____ Name of Firm: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number : _____

Producer Number: _____ Commission: _____

- Broker of Record for this risk? Yes _____ No _____
- Is Broker licensed in contract situs state? Yes _____ No _____
- Is the license a: resident license _____
non-resident license _____
- Is the license for: Accident & Health _____
Property & Casualty _____
Both _____
- Is the Broker licensed in the situs state for Surplus lines? Yes _____ No _____
If yes, please provide license number: _____

INSURANCE PLAN DESIGN

A. OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum * [\$50,000]

Accident Commencement Period [365 days]

Survivor's Benefit:

Principal Sum * [\$175,000]

[Monthly Benefit Percentage [1.0%]]

[Monthly Benefit Amount [\$1,750]]

Accidental Dismemberment Benefit:

Principal Sum * [\$225,000]

Accident Commencement Period [365 days]

Paralysis Benefit:

Principal Sum *[\$225,000]
Accident Commencement Period [365 days]

Temporary Total Disability Benefit:

Disability Commencement Period..... [90 days]
Waiting Period [7 days]
Benefit Percentage [66.67%]
Minimum Weekly Benefit Amount [\$125]
Maximum Weekly Benefit Amount..... [\$475]
Maximum Benefit Period ** [104 weeks]
[**Maximum Benefit Period for Hernia**..... [10 weeks]]
[**Maximum Benefit Period for Occupational Cumulative Trauma**
and/or **Repetitive Conditions** [10 weeks]]

Continuous Total Disability Benefit: ***

Waiting Period [**Maximum Benefit Period for Temporary Total Disability**]
Benefit Percentage [66.67%]
Minimum Weekly Benefit Amount [\$50]
Maximum Weekly Benefit Amount..... [\$475]
Maximum Benefit Amount [\$300,000]
Maximum Benefit Period..... [to age 70]

Accident Medical Expense Benefit:

Medical Commencement Period [90 days]
Deductible Amount [\$0]
Maximum Benefit Period..... [104 weeks]
Dental Maximum [\$1,000.00 per **Accident**]
Maximum Benefit Amount per Accident..... [\$750,000]
Lifetime Maximum Benefit [\$100,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy [[\$1,000] per **Injury**]
..... [and] [a combined [36] visits]
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
Occupational Therapy, Work Hardening Therapy [\$1,000] per **Injury**
Ambulance [[one] round trip to and from a **Hospital**]
[but] [not more than [\$1,000] for any one **Accident**]
[Air Ambulance] [[one] round trip to and from a **Hospital**]
[but] [not more than [\$7,000] for any one **Accident**]]
[Hernia Coverage]..... lifetime **Maximum Benefit** of [\$10,000]]
Mental and Nervous – Outpatient..... [[\$25.00] per visit]
maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient..... [maximum [20] days]
[maximum [\$1,000] for any one **Accident**]
[**Occupational Cumulative Trauma** and/or
Repetitive Conditions..... lifetime **Maximum Benefit** of [\$10,000]]

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$750,000]
- **Aggregate Limit of Liability** [\$1,500,000]
(applicable to all **Covered Losses** with respect to any one **Occupational Accident**)
- [Hernia Coverage].....combined lifetime **Maximum Benefit** of [\$15,000]]
- [**Occupational Cumulative Trauma** and/or
Repetitive Conditions.....combined lifetime **Maximum Benefit** of [\$15,000]]
- [**Pre-Existing Condition** Limitation [\$10,000]]

B. NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:

Principal Sum *[\$7,500]
Accident Commencement Period [365 days]

Accidental Dismemberment Benefit:

Principal Sum * [\$7,500]
Accident Commencement Period [365 days]

Accident Medical Expense Benefit:

Medical Commencement Period [90 days]
Deductible Amount [\$0]
Maximum Benefit Period [52 weeks]
 Dental Maximum [\$1,000 per **Accident**]
Maximum Benefit Amount per Accident [\$5,000]
Lifetime Maximum Benefit [\$10,000]

Limits on Accident Medical Expense Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy [[\$1,000] per **Injury**]
 [and][a combined [36] visits]
 Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy,
 Occupational Therapy, Work Hardening Therapy [\$1,000] per **Injury**
 Ambulance [[one] round trip to and from a **Hospital**]
 [but][not more than [\$1,000] for any one **Accident**]
 [Air Ambulance [[one] round trip to and from a **Hospital**]
 [but][not more than [\$7,000] for any one **Accident**]
Mental and Nervous – Outpatient [[\$25.00] per visit]
 [maximum [20] visits for any one **Accident**]
Mental and Nervous – Inpatient [maximum [20] days]
 [maximum [\$1,000] for any one **Accident**]

NON-OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** [\$7,500]
- **Aggregate Limit of Liability** [\$15,000]
 (applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

* At age [65], the **Insured Person's Principal Sum** will be based on the following schedule:

<u>Age at Date of Loss</u>	<u>% of Principal Sum</u>
65	[80%]
66	[60%]
67	[40%]
68	[20%]
69	[15%]
[70 and over]	[10%]

** If an **Insured Person** sustains a **Covered Injury** at or after age [70], the **Maximum Benefit Period** will be [one (1) year].

*** If an **Insured Person** sustains a **Covered Injury** after the **Insured Person's** normal Social Security retirement age, as determined by federal law, the **Insured Person** cannot qualify for **Continuous Total Disability**.

[FRAUD STATEMENT

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

The undersigned:

1. Declares that all information provided in this Application and any attachments hereto is true and correct. He or she understands that all information provided in this Application and any attachments hereto is material to Atlantic Specialty Insurance Company’s decision to provide this insurance, and that insurance will be provided, at Atlantic Specialty Insurance Company’s sole discretion, in reliance upon the truth of such information.
2. Understands and agrees that the insurance applied for will not become effective until the Application for Occupational Accident Insurance coverage is approved by the Insurer, and the initial premium deposit, if applicable, is received; and
3. Agrees that if the insurance applied for is approved by Atlantic Specialty Insurance Company, he or she will pay all premium due after the Effective Date of the insurance, including any premium which may accumulate between the Effective Date of the insurance and the date the Policy is issued.

If coverage is issued, this Application will be made part of the Policy.

Application completed by: _____
(Risk manager or the person responsible for insurance procurement)

On Behalf of Motor Carrier: _____

Signature of Authorized Person: _____ Date: _____

Print Name: _____ Title: _____

FOR HOME OFFICE USE ONLY

APPROVED: YES _____ NO _____

DATE: _____



DRIVER ENROLLMENT AND BENEFICIARY FORM
TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

Please print:

Name: _____ Male: _____ Female: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Social Security Number: _____ Date of Birth: _____ E-Mail Address: _____
 Home Telephone Number: _____ Cell Telephone Number: _____
 Name of Beneficiary: _____ Relationship of Beneficiary: _____
 CDL Number: _____ Number of Years Experience: _____
 Contracted by (Name of Company): _____ Effective Date of Contract: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Motor Carrier Telephone Number: _____ Fax Number: _____
 Motor Carrier E-Mail Address: _____

Please answer the following general questions:

- Are you an Owner-Operator? Yes _____ No _____
 If yes, is the Certificate of Title in your name? Yes _____ No _____
 If no, are you a: Co-Owner _____ Leased Driver _____ Team Driver _____ Contract Driver _____ or Employee _____
- Do you drive for another person? Yes _____ No _____
- Do you load/unload? Yes _____ No _____
 If yes, what is the average weight you lift? _____
- Do you attach and detach the trailer? Yes _____ No _____
- Do you tarp? Yes _____ No _____
- Do you drive: Automatic _____ or Shift _____
 Long Haul _____ or Short Haul _____
- Do you receive: 1099 _____ or W-2 _____
- What other duties do you perform? _____

Please answer the following medical questions:

- Are you covered under any medical plan? Yes _____ No _____
 If yes, identify: _____
- Have you ever filed a claim for Workers' Compensation or any other occupational related injury? Yes _____ No _____
 If yes, explain: _____
- Have you ever been treated for:

back, neck, spinal impairment _____	arthritis/gout _____
disorder of muscle or bone _____	hemorrhoids _____
high/low blood pressure _____	prostatitis _____
kidney condition _____	diabetes _____
heart condition _____	hernia _____

 If yes, explain: _____
- Are you presently using any prescription medication? Yes _____ No _____
 If yes, explain: _____

- Have you had any disease or injury, within the past five (5) years, not listed above? Yes _____ No _____
If yes, explain: _____
- Have you ever been treated for alcohol or drug dependency? Yes _____ No _____
If yes, explain: _____
- What is the name and address of your current physician?
Your Physician's Name: _____
Your Physician's Street Address: _____ City: _____ State: _____ Zip: _____

[FRAUD STATEMENT

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

In providing this information, I, the undersigned, understand and hereby state that:

1. to the best of my knowledge and belief, all information on this Form is complete and truthful;
2. this coverage being is not a contract for Statutory Workers' Compensation Insurance, and neither I nor my carrier become participants in the Workers' Compensation system by purchasing this insurance; and
3. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

By my signature below, I, the undersigned, also authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records, to furnish such information or copies of records to Atlantic Specialty Insurance Company, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.

**IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT,
THE INSURER HAS THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.**

In order to verify the information provided in this Form, I, the undersigned, give the Insurer authority to examine the records that are maintained by the motor carrier.

[I certify that I am an independent contractor, paid by a 1099 tax form, not as a W-2 employee.]

Driver's Signature: _____ Date: _____

[Motor Carrier] Representative's Signature: _____

Payment Authorization: I authorize the above named motor carrier, with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Atlantic Specialty Insurance Company.

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to Atlantic Specialty Insurance Company, upon demand, for any insurance at any time my account remains unpaid.

Signature: _____ Date: _____

<i>SERFF Tracking Number:</i>	<i>CLTR-127385968</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Atlantic Specialty Insurance Company</i>	<i>State Tracking Number:</i>	<i>49717</i>
<i>Company Tracking Number:</i>	<i>AH 200A OA AR F</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Group Occupational Accident</i>		
<i>Project Name/Number:</i>	<i>Occupational Accident Filing/</i>		

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments:</p> <p>AR OCC Readability Cert.pdf</p> <p>Rule and Regulation 19 Certification.pdf</p> <p>For Residents of Arkansas.pdf</p>	Approved-Closed	09/08/2011
<p>Satisfied - Item: Application</p> <p>Comments:</p> <p>Application attached to Form Schedule.</p>	Approved-Closed	09/08/2011
<p>Satisfied - Item: Authorization to File</p> <p>Comments:</p> <p>Attachment:</p> <p>ASIC Authorization to File.pdf</p>	Approved-Closed	09/08/2011

READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

<u>Form</u>	<u>Form Number</u>	<u>Flesch</u>
Group Policy	AH 200A OA CW 08 11	40.0
Certificate of Insurance	AH-202A OA CW 08 11	40.7
Administrative Changes Rider	AH 203A OA CW 08 11	44.2
Policyholder Application	AH 204A OA AR 08 11	46.7
Driver Enrollment and Beneficiary Form	AH 205A OA AR 08 11	46.5

B. Test Option Selected

1. Test was applied to entire form(s).
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: Atlantic Specialty Insurance Company

Signature of Certifying Official: 

Printed Name and Title of Certifying Official: Keith Firestone, Assistant Secretary

Certifying Official's Address: 1 Beacon Lane, Canton MA 02021-1030

Date Signed: August 26, 2011

TO: Commissioner of Insurance
Arkansas Insurance Department

RE: Atlantic Specialty Insurance Company

RULE AND REGULATION 19 CERTIFICATION

This is to certify that the referenced certificate of coverage form complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed for Atlantic Specialty Insurance Company by

9/6/2011
Date

Keith Firestone
Signature

Keith Firestone, Assistant Secretary
Typed Name and Title

For Residents of Arkansas: IMPORTANT NOTICE: ARKANSAS INSURED'S ACCESS TO INSURER INFORMATION: This notice is to comply with Arkansas House Bill 1221. We are required by law to notify you of the complete addresses and phone numbers of the Arkansas Insurance Department, the insurance company's servicing office, and the agent.

Below is this information: Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, Arkansas 72201-1904, Telephone: 1-800-852-5494.

Servicing Office:
OneBeacon
44 Whippany Road
Morristown, NJ 07960



Date: August 23, 2011
To: State Insurance Departments
From: Dennis R. Smith
Subject: Filing Authority for Coulter & Associates, Inc.

I, Dennis Smith, an officer of Atlantic Specialty Insurance Company, have authorized Coulter & Associates, Inc., acting as our Contracts Consultants, to file products and correspond with your Department on our behalf.

This Authorization is effective until August 31, 2012.

Officer Signature: _____  _____

Title: Secretary