

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: Single Case LB Association Filing - NACD
Project Name/Number: NACD Single-Case LB Association Filing/AH990017 - NACD

Filing at a Glance

Company: Wesco Insurance Company
Product Name: Single Case LB Association Filing - NACD
State: Arkansas
TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Form
Date Submitted: 10/10/2012
SERFF Tr Num: UNKP-128719102
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AH990017 NACD

Implementation: On Approval
Date Requested:
Author(s): Susan Coulter
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/26/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: Single Case LB Association Filing - NACD
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General Information

Project Name: NACD Single-Case LB Association Filing Status of Filing in Domicile:
Project Number: AH990017 - NACD Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Association Overall Rate Impact:
Filing Status Changed: 10/26/2012 Deemer Date:
State Status Changed: 10/26/2012 Submitted By: Susan Coulter
Created By: Susan Coulter
Corresponding Filing Tracking Number: UNKP-128614623

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

On 8/7/12 the Department approved policy form AH990017 LB and related forms SERFF Tracking No. UNKP-128614623 for use in your state. The Company has recently issued a policy to the NACD association that have members in your state. This association is situated in Illinois. Accordingly, the Company would like to issue the approved certificate of coverage (WIC-AH-AD-CERT NACD AR) to members of this association residing in your state. In accordance with your requirements we are submitting to you the articles of incorporation and by-laws for this association for your review and approval. The Company would also like approval of this association for use with other products as they are approved by the Department.

National Association of Consumer Direct (NACD) – Illinois situs – Founded in 2001 as the National Internet Consumers Association, “The purpose of the association is “...’educational’ as stated in the Certificate of Incorporation, as well as any powers as are now or may hereafter be granted by the General Not-For-Profit Law of the State of Illinois . The purpose of the association shall be further states as providing consumer-related educational resources and access to affordable consumer benefits, products and services by leveraging the Association’s group purchasing power.” (By-Laws, Article I, Purposes)

We trust you will find the association acceptable. Please do not hesitate to contact us at wendy@coulter-and-associates.com or by phone at (609) 443-7540 should you have any questions.

Company and Contact

Filing Contact Information

Susan Coulter, susan@coulter-and-associates.com
379 Princeton-Hightstown Road, 609-443-4140 [Phone]
Suite 15
Cranbury, NJ 08512

State: Arkansas **Filing Company:** Wesco Insurance Company
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Filing Company Information

Wesco Insurance Company	CoCode: 25011	State of Domicile: Delaware
59 Maiden Ln, 6th Fl	Group Code: 2538	Company Type: Property &
New York, NY 10038	Group Name: AmTrust Financial	Casualty
(212) 220-7120 ext. [Phone]	Group	State ID Number:
	FEIN Number: 85-0165753	

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? Yes
 Fee Explanation: \$50.00/form 1 form @ \$50.00 = \$50.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
Wesco Insurance Company	\$50.00	10/10/2012	63648572

SERFF Tracking #:

UNKP-128719102

State Tracking #:

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AH990017 NACD

State: Arkansas

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Filing Company:

Wesco Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/26/2012	10/26/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/11/2012	10/11/2012

Response Letters

Responded By	Created On	Date Submitted
Susan Coulter	10/24/2012	10/24/2012

SERFF Tracking #:

UNKP-128719102

State Tracking #:

Company Tracking #:

AH990017 NACD

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Single Case LB Association Filing - NACD

Project Name/Number:

NACD Single-Case LB Association Filing/AH990017 - NACD

Disposition

Disposition Date: 10/26/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Approved Policy for NACD	Approved-Closed	Yes
Supporting Document	NACD Governance Documents	Approved-Closed	Yes
Form (revised)	Limited Benefits Certificate	Approved-Closed	Yes
Form	Limited Benefits Certificate	Replaced	Yes

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: Single Case LB Association Filing - NACD
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/11/2012
Submitted Date	10/11/2012
Respond By Date	11/12/2012

Dear Susan Coulter,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- NACD Governance Documents (Supporting Document)
 - Limited Benefits Certificate, WIC-AH-AD-CERT (0312) NACD AR (Form)
- Comments:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81. Also, does the association meet the requirements outlined under ACA 23-86-106(2)(A)(ii)(iii)?

Thank you for your cooperation.

Conclusion:

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 #:

UNKP-128719102

State Tracking #:

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AH990017 NACD

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/24/2012
Submitted Date	10/24/2012

Dear Rosalind Minor,

Introduction:

Please refer to the revised Certificate attached to t his filing.

Response 1

Comments:

The revised Certificate is without the time limit set for furnshing proof of incapacity for handicapped dependents.

Related Objection 1

Applies To:

- Limited Benefits Certificate, WIC-AH-AD-CERT (0312) NACD AR (Form)
- NACD Governance Documents (Supporting Document)

Comments:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81. Also, does the association meet the requirements outlined under ACA 23-86-106(2)(A)(ii)(iii)?

Thank you for your cooperation.

Changed Items:

No Supporting Documents changed.

State: Arkansas
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Filing Company: Wesco Insurance Company

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Limited Benefits Certificate	WIC-AH-AD-CERT (0312) NACD AR	CER	Initial		50.600	WIC-AH-AD-CERT (0312) NACD AR (20121009 cc).pdf	Date Submitted: 10/24/2012 By: Susan Coulter
<i>Previous Version</i>								
1	<i>Limited Benefits Certificate</i>	<i>WIC-AH-AD-CERT (0312) NACD AR</i>	<i>CER</i>	<i>Initial</i>		<i>50.600</i>	<i>WIC-AH-AD-CERT (0312) NACD AR (20121009 cc).pdf</i>	<i>Date Submitted: 10/10/2012 By: Susan Coulter</i>

No Rate/Rule Schedule items changed.

Conclusion:

I believe you will find this acceptable for approval. Should you have further questions or need additional information, please contact me.

Many thanks.

Sincerely,

Susan Coulter

SERFF Tracking #:

UNKP-128719102

State Tracking #:

Company Tracking #:

AH990017 NACD

State: Arkansas

Filing Company:

Wesco Insurance Company

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Form Schedule

Lead Form Number: WIC-AH-AD-CERT (0312) NACD AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/26/2012	Limited Benefits Certificate	WIC-AH- AD-CERT (0312) NACD AR	CER	Initial		50.600	WIC-AH-AD-CERT (0312) NACD AR (20121009 cc).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

**Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038**

Policyholder: National Association of Consumer Direct

Policy Number: NACD1234567

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

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Definitions
Insured Person Period of Coverage
[Insured Dependent Period of Coverage]
Premiums
General Exclusions
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Claims

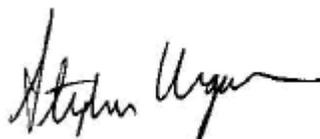
Group Limited Benefits Certificate of Coverage

THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS CERTIFICATE CAREFULLY.

Signed for Wesco Insurance Company



President



Secretary

NEED ASSISTANCE? If you have a question or wish to obtain information about Your coverage, or You require assistance in resolving a complaint, please contact us at 1-800-215-7265.

GENERAL DEFINITIONS

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

Confined and Confinement mean:

1. being admitted to a Hospital for receiving inpatient hospital services; and
2. the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.
3. Not one of the following:
 - a. A person who ordinarily resides in Your household
 - b. A member of Your immediate family
 - c. The Policyholder.

Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner are not legally married to anyone else.

Hospital means an institution which:

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

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

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.†

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident and independently of all other causes which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2. medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or Insured Person means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
 - a. cease to be an Eligible Person;
 - b. attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
 - c. fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

1. are not eligible for the coverage requested, the change will not become effective;
2. are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:

1. **Spouse** means Your spouse [or Domestic Partner] unless:
 - a. You and Your spouse are legally separated or divorced [the domestic partnership is dissolved]; or
 - b. He or she has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means Your unmarried child, stepchild, legally adopted child from the date of placement, or foster child:

- a. who is less than age 19 and primarily dependent on You for support and maintenance; or
- b. under the age of 26 if a resident of Florida who is enrolled as full or part-time student at an institution of learning and primarily dependent on You for support and maintenance.

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:

1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:

1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:

1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:

1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:

1. is not eligible for the coverage requested, it will not become effective; or

2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

Incapacitated Child: Coverage of a child who, on the date he or she reaches age 19 or 26, is:

1. covered under the Policy;
 2. mentally or physically incapable of earning his or her own living; and
 3. unmarried and primarily dependent on You for support and maintenance;
- will not terminate solely due to age.

However, You must give Us written notice of the incapacity.

Coverage will continue as long as:

1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.}

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony;

BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.

IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result, from no other causes, of Injuries sustained in a Covered Accident.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;

4. the date insurance under the Policy ends.}

NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion: In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

This benefit is not available to Covered Dependent Children.

Definitions: In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or Totally Disabled means during the first twelve (12) months that You are unable to perform the material and substantial duties of Your regular occupation. After the first twelve (12) months, Total Disability means You are unable to perform any work or occupation for which You are reasonably qualified or trained.

EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the Covered Injury; and
4. the medical expenses are incurred within 52 weeks of the Covered Injury.

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

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses

11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
 12. X-ray expenses (including reading charges) but not for dental X-rays
 13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
 14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
 15. Ambulance expenses for transportation from the emergency site to the Hospital.
 16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
 17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
 18. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
 19. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.
- Exclusions:** In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:
1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
 2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
 3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
 4. Travel outside of the United States of America.
 5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
 6. Treatment by an Immediate Family Member.
 7. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.
 8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless

Medically Necessary for the treatment of the Covered Injury.

9. A hernia.
10. Routine physical examinations and related medical services or elective treatment or surgery or Experimental/Investigational treatments or procedures.
11. A Medical Repatriation.
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the Covered Person is not legally obligated to pay.
14. Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.
15. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.
16. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.
17. being legally intoxicated while operating a motor vehicle.
 - a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.
18. Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.).

Definitions: In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

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

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1. on a monthly basis, after We receive the proof of loss, while the loss and liability continue; or
2. immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to \$1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;

2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right, at our expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: The group policy is non-assignable. You may not assign any of the Policyholder's rights or privileges under the Policy. However, You may assign the benefit to which You are entitled to a provider of services. If an irrevocable beneficiary has been designated, that person must give written consent to any assignment. No assignment will be binding on Us unless it is in writing and a copy is sent to Us. We accept no responsibility for the validity of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.

SERFF Tracking #:

UNKP-128719102

State Tracking #:

Company Tracking #:

AH990017 NACD

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Single Case LB Association Filing - NACD

Project Name/Number:

NACD Single-Case LB Association Filing/AH990017 - NACD

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/26/2012
Comments:			
Attachment(s):	AR LB Flesch Certification-Assoc Filing 20121008 NACD.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/26/2012
Comments:			
Attachment(s):	Group App - Modified for AR (20120103 cc).pdf		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	10/26/2012
Bypass Reason:	Not applicable-not individual or Group/Individual Long Term Care and Medicare Supplement Filings.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/26/2012
Bypass Reason:	Not an Individual Health Product, Group/Individual Medicare Supplement or Long Term Care		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/26/2012
Bypass Reason:	Not PPACA related.		
		Item Status:	Status Date:
Satisfied - Item:	Approved Policy for NACD	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			

SERFF Tracking #:

UNKP-128719102

State Tracking #:

Company Tracking #:

AH990017 NACD

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Single Case LB Association Filing - NACD

Project Name/Number:

NACD Single-Case LB Association Filing/AH990017 - NACD

AH990017 (0312) - CW - GROUP POLICY.pdf

WIC-AH-AD-CERT IL (20120314 cc).pdf

WIC Rider EME (20120319 cc).pdf

WIC Rider ER (20120319 cc).pdf

		Item Status:	Status Date:
Satisfied - Item:	NACD Governance Documents	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
1 - NACD Articles of Incorporation (3-1-01).pdf			
2 - NACD Amended By-Laws (4-28-09).pdf			

WESCO INSURANCE COMPANY

FLESCH CERTIFICATION

I, Barry W. Moses an office of Wesco Insurance Company, certify that the forms listed below satisfy the NAIC Model Bill standards of life and health insurance policy language simplification legislation.

Form Number	Form Title	Flesch Score
WIC-AH-AD-CERT NACD AR	Group Certificate	50.6

Signature of Office: _____



Title: Vice President, Regulatory Compliance

Date: 10/8/2012

**Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038**

Section I - Administrative Information

[Association]/Policyholder Name					
Policyholder Street Address (No P.O. Box)		City	State	Zip	County
Mailing Address (if different from above)		City	State	Zip	County
Phone ()	Administrative Contact				
Fax ()	Title				
Requested Effective (MM/DD)[01]/YYYY	Email Address				
Describe the Nature of [Association][Business]					
[Will any of the selected coverage types be a takeover for an existing group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please specify coverage types_____ Effective date of prior coverage types_____					
Prior Carrier Name_____ Termination date of prior coverage types_____]					

Section II - Eligibility Requirements

Members in good standing of the association are eligible for insurance under the program. [Dependents of the Member are also eligible]	
6. [Eligibility Waiting Period <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Number of days <input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other_____	
[Waiting Period applies to:	
<input type="checkbox"/> Persons who are Members in good standing prior to the effective date]	
<input type="checkbox"/> Actively at work employees working _____ hours per week.	
<input type="checkbox"/> Persons who become Members after the Policy Effective Date]	
[Do different classes have a different waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe:_____]	

Section III – Benefits Selected:

Accidental Death and Dismemberment for all Covered Persons

Principal Sum Amount Options: [\$5,000-\$100,000]

Dependents Principal Sum is based on a percent of the Insured Person's Principal Sum:

	Spouse/Domestic Partner	Each Child
Insured Person with Covered:*		
Spouse [Domestic Partner], but no covered Child	50%	0%
Spouse [Domestic Partner]and Child(ren)	40%	10%
Child(ren), but no covered Spouse[Domestic Partner]	0%	15%

Accident Hospital Indemnity Benefit for all Covered Persons:

Daily Hospital Confinement Benefit Amount: [\$xxx-\$xxx]
Maximum Benefit Period: [xxx] Days Per Confinement

Non-Occupational Weekly Disability Income Benefits for Insured Person Only

Weekly Disability Benefit: [\$\$\$-XXX] reduced by the Reduction of Benefits Due to Other Sources of Income provision in the certificate
Benefit Waiting Period [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]
Maximum Benefit Period of Disability [13, 26 weeks.]

Accident Excess Medical Expense Benefit for all Covered Persons:

Deductible: [\$100-\$200 per Certificate Year]
Coinsurance: [20%]
Maximum Benefit Amount per Covered Person per Covered Accident: [\$10,000]
Benefit Limitations: Maximum Benefit Amount for Accident Dental: [\$1,000]

Emergency Room Benefit:

Amount Per Injury or Sickness: [\$1,000-\$5,000]
Annual Maximum Benefit Amount [\$1,000-\$5,000] per Covered Person

Emergency Medical Evacuation Benefit:

Amount Per Evacuation: [\$5,000-\$50,000]
Minimum Number of Miles for Emergency Evacuation: [100-200]

Section V - General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. [Payment of the first premium by the policyholder after delivery of the Policy by us shall constitute acceptance of the terms and conditions contained in the Policy so issued.]
2. [All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to us by the Policyholder.]
3. [This Application is subject to the approval of Wesco Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.]
4. [All benefits will be in accordance with the benefits proposed and agreed upon between Wesco Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.]

Policyholder responsibilities under this policy

The Policyholder agrees:

1. to maintain the records necessary to the administration of the Policy(s) and to make such records available to Wesco Insurance Company or its authorized administrator to ensure proper administration of the program;
2. to report additions, changes, terminations and other information necessary to the administration of the Policy(s) to the Wesco Insurance Company within 31 days after the Effective Date of such additions, changes and terminations;
3. [to pay all premiums in accordance with the terms of this Policy]; and
4. to notify all Insured Persons of any termination or rescission of coverage which affects them and refund the appropriate premium.]

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Wesco Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers We have provided are representations and not warranties.

BEFORE SIGNING THE APPLICATION, PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

(Arkansas) 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.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

(Louisiana/Tennessee) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(New Mexico) 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 civil fines and criminal penalties.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please Sign and Date

Dated at _____ this _____ day of _____, _____ / _____ / _____
City and State Date Month Year

By _____
Signature of Association Printed name of Association Job Title

[Association's Signature witnessed by (must be 18 or older):

Signature of Witness Printed name of Witness Date]

[Signature of Agent/Producer:]

Signature of Agent/Producer Printed name of Agent/Producer Date]

Section VI - Producer Information

Company/Brokerage Name
Company Address (if different than above) City, State Zip

Name of Agent Representing this Group		
Phone () -	Fax () -	Email Address
Producer Number		

Send Completed Application to:
[address]

Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

GROUP LIMITED BENEFITS INSURANCE POLICY

Policyholder Name: National Association of Consumer Direct (NACD)

Policy Number: NACD1234567

Policyholder Address:

Place of Delivery:

Policy Effective Date: January 1, 2012

Policy Anniversary:

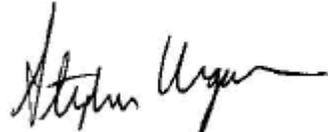
In return for the application, which is attached, and payment of premium as it becomes due, Wesco Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown above.

Signed for the Company



President



Secretary

THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS POLICY CAREFULLY.

TABLE OF CONTENTS

Schedules
Premium Provisions
Contract Provisions
Certificate of Insurance
Riders (if any)

SCHEDULE OF ELIGIBLE PERSONS

ELIGIBLE PERSONS:

ELIGIBLE MEMBER:

[All active members in good standing of the Policyholder who are:

- a) under age [60-85];
- b) full-time residents of the United States; and
- c) not full-time members of any country's armed forces.]

[All full time employees working at least [17.5 - 40] hours per week. The employee must be Actively at Work in order for insurance to take effect.]

ELIGIBLE DEPENDENTS: Eligible Person's Spouse [Domestic Partner] and Child(ren)
An Eligible Spouse [Domestic Partner] and/or Child may only be covered if the Eligible Person is covered under this Policy.

When an Eligible Person and his or her Spouse [Domestic Partner] are both Eligible Persons:

- a) coverage may not be duplicated by enrolling as Dependents of each other; and
- b) coverage for an Eligible Child may be requested only by the Eligible Person or the Eligible Dependent Spouse [Domestic Partner], but not both.

No Eligible Child can be covered unless the Eligible Person or Eligible Spouse [Domestic Partner] is covered under this Policy.]

POLICY AGE LIMIT: [None-100]

EVIDENCE OF INSURABILITY: None

Eligibility Waiting Period: [as determined by the Policyholder from the first day of eligibility]
[1-60 Days] [1-3 Months] from the first day of Active Work]
[1-60] [Days][1-3 Months]from the date a person first became a Member
in good standing of the Policyholder]

Method of Premium Payment: [Remitted by Policyholder] [Remitted by Insured Person To Us]

SCHEDULE OF BENEFITS

BENEFITS AND AMOUNTS:

[Accidental Death and Dismemberment Benefit

Insured Person Principal Sum Amount
[\$5,000-\$100,000]

Principal Sum For each Insured Person's Eligible Dependents:

The Principal Sum applicable to each person covered under this policy as an Insured Person's Dependent is calculated by applying the percent, determined below, to the Insured Person's Principal Sum.

Insured Person with Covered:*	Spouse/Domestic Partner	Each Child
Spouse, but no covered Child	50%	0%
Spouse and Child(ren)	40%	10%
Child(ren), but no covered Spouse	0%	15%

*As determined on the date of accident

[Accidental Death and Dismemberment Reduction on and after Age 65: On the Premium Due Date on or next following a Covered Person's attainment of age 65, his or her amount of Principal Sum will reduce by 50%.]

[Accidental Death Reduction on and after Age 70: On the Premium Due Date on or next following the Covered Person's attainment of :

- a) age 70, his or her amount of Principal Sum will reduce by 50%; and
- b) age 75, his or her amount of Principal Sum will reduce further by 50%.]

[Aggregate Limit of Liability: [\$1,000,000 - \$10,000,000]

Aggregate Limit of Liability means the total Accidental Death and Dismemberment benefit amount that We will pay for all Covered Persons involved in a single Covered Accident who suffer a Cover Loss. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each Covered 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.]

[Accident Hospital Indemnity Benefit for all Covered Persons:

Daily Hospital Confinement Benefit Amount: [\$30-\$500]
Maximum Benefit Period: [30-365] Days Per Confinement]

[Non-Occupational Weekly Disability Income Benefits for Insured Person Only

Weekly Disability Benefit: [\$100 - \$2,000] reduced by the Recution of Benefits Due to Other Sources of Income provision in the certificate
Benefit Waiting Period [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]]
Maximum Benefit Period of Disability [13, 26 weeks.]]]

[Accident Excess Medical Expense Benefit for all Covered Persons:

Deductible: [\$100-\$200]
Coinsurance: [10-30%]
Maximum Benefit Amount per Covered Person per Covered Accident: [\$1,000 - \$50,000]
Benefit Limitations: Maximum Benefit Amount for Accident Dental: [\$750-\$5,000]]

SCHEDULE OF PREMIUMS

INDIVIDUAL PREMIUMS: The premium is on file with the Policyholder.

ENROLLMENT

INITIAL ENROLLMENT: For Members who are eligible on the Policy Effective Date, Members should enroll within [0-60 days] of the Policy Effective Date. Members who are eligible after the Policy Effective Date should enroll themselves and their Eligible Dependents within [0-60 days] of their Eligibility Waiting Period. Members who do not enroll within the Eligibility Waiting Period must wait until the next Open Enrollment Period.

OPEN ENROLLMENT: Members may enroll themselves and their Eligible Dependents during an Open Enrollment Period. Other changes may also be restricted to Open Enrollment Periods.

Open Enrollment Period means the period of time specified by the Policyholder during which an Eligible Member may enroll for insurance if he or she did not enroll during the Eligibility Waiting Period. It usually occurs once each Policy Year but may, at the Policyholder's discretion, occur more frequently, if approved by Us.

PREMIUM PROVISION

POLICY PREMIUM: The premium for this policy is on file with the Policyholder.

PREMIUM DUE DATES: The Policy Premium is payable on the Policy Effective Date and each year thereafter. Each Policy Premium is due in advance of the date it becomes payable.

This policy terminates on the last day of the period for which premium is paid unless continued in force during a grace period.

PAYMENT: The Policy Premiums are to be paid to us by the Policyholder. However, they may be paid to us by any other person according to a mutual agreement among the other person, the Policyholder and us.

GRACE PERIOD: A grace period of 31 days is allowed for payment of each premium due after the first unless this policy is cancelled on or before the due date. This policy will continue in force during the grace period. The Policyholder is liable to us for the payment of premium accruing for the period this policy continues in force.

CHANGE OF PREMIUMS: We have the right on any date after the first anniversary, to change the rate at

which further premiums will be calculated. We will give the Policyholder notice of any change at least [30, 45, 60] days before the Due Date on which it is to become effective.

CONTRACT PROVISIONS

ENTIRE CONTRACT: The entire contract between the Policyholder and Us consists of this policy, the certificate of insurance, any individual enrollment forms, the group application, and any papers made a part of this policy at issue.

CHANGES: No agent has authority to change or waive any part of this policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made a part of this policy.

TIME PERIODS: All periods begin and end at 12:01 A.M., Standard Time at the place where this policy is delivered.

CERTIFICATES: We will give certificates to:

- a) the Policyholder; or
- b) any other person according to a mutual agreement among the other person, the Policyholder, and us; for delivery to Insured Persons.

The certificates will state the features of this policy which are important to Insured Persons.

NEW ENTRANTS: New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

DATA FURNISHED BY POLICYHOLDER: The Policyholder will, upon Our request, give us:

- a) the names of all persons initially eligible;
- b) the names of all additional persons who become eligible;
- c) the names of all persons whose benefits are to be changed;
- d) the names of all persons whose insurance is canceled; and
- e) any data necessary to calculate premiums.

The Policyholder's failure to report a person's termination of insurance does not continue the coverage beyond the date of termination.

The Policyholder, with Our approval, may keep the important insurance records on all Covered Persons. The Policyholder must give Us information, when and in the manner We ask, to administer the insurance provided by this policy.

The Policyholder's insurance records will be open for Our inspection at any reasonable time.

CANCELLATION: This policy may be canceled at any time by written notice mailed or delivered by Us to the Policyholder or by the Policyholder to Us. If We cancel, We will mail or deliver the notice to the Policyholder at its last address shown in Our records.

If We cancel, it becomes effective on the later of:

- a) the date stated in the notice; or
- b) the 31st day after We mail or deliver the notice.

If the Policyholder cancels, it becomes effective on the later of:

- a) the date We receive the notice; or
- b) the date stated in the notice.

In either event:

- a) We will promptly return any unearned premium paid; or

- b) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis.

Cancellation will not affect any claim for loss due to an accident which occurs before the effective date of the cancellation.

NOT IN LIEU OF WORKERS' COMPENSATION: This policy does not satisfy any requirement for workers' compensation insurance.

INCORPORATION PROVISION: The Certificate(s) of Insurance and Riders listed below are attached to, incorporated in and made a part of this Policy.

<u>Form</u>	<u>Applicable To</u>	<u>Effective Date of Incorporation</u>
Certificate of Insurance Form	All Eligible Persons	January 1, 2012
Rider Form WIC RIDER EME	All Eligible Persons	January 1, 2012
Rider Form WIC RIDER ER	All Eligible Persons	January 1, 2012

**Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038**

Policyholder: National Association of Consumer Direct (NACD)

Policy Number: NACD1234567

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

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Accident-Only Certificate of Coverage

LIMITED BENEFIT

THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ YOUR CERTIFICATE CAREFULLY.

Signed for Wesco Insurance Company

GENERAL DEFINITIONS

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

[Active Work and Actively at Work – The eligible employee is performing all of the usual and customary duties of his or her or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the person to travel.]

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

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Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

[Confined and Confinement mean:

- a) being admitted to a Hospital for receiving inpatient hospital services; and
- b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.]

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.

3. Not one of the following:
 - A person who ordinarily resides in Your household
 - A member of Your immediate family
 - The Policyholder.

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
- [5. [You and Your Domestic Partner have filed a Domestic Partner affidavit with Us; and]
6. You and Your Domestic Partner are not legally married to anyone else.]

[Hospital means an institution which, on its premises or in facilities available to the Hospital on a pre-arranged basis, meets fully each of the following requirements:

1. is operated in accordance with the laws pertaining to Hospitals in the jurisdiction in which it is located;
2. is under the supervision of a medical staff and has one or more Physicians available at all times;
3. provides 24 hours a day service by registered graduate nurses (RNs); and
4. is not, other than incidentally, a place for the aged, a place for the mentally ill, or a nursing or convalescent home.

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

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.]

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident, independent of disease or bodily infirmity, and which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except bacterial infection which results from an accidental injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; or
 2. medical or surgical treatment of a sickness or disease;
- is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or Insured Person means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

[You must be Actively At Work on the date Your insurance becomes effective. (If the date that insurance was to go into effect is not a normally scheduled work day for You, You must have been Actively at Work on the last scheduled work day prior to the date insurance becomes effective under the Policy). If You are not so Actively at Work, Your insurance will be deferred until the date You are Actively at Work.]

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
 - a) cease to be an Eligible Person;
 - b) attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
 - c) fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

- a) are not eligible for the coverage requested, the change will not become effective;
- b) are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:

1. Your spouse; [or lawful Domestic Partner]
2. Your unmarried dependent child who is a non-military dependent under age 26 and who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. A child who is in Your custody pursuant to an interim court order of adoption or placement of adoption, whichever comes first, vesting temporary care of the child in You, regardless of whether or not a final order granting adoption is ultimately issued;
4. Your unmarried child who is a military veteran dependent, who is under age 30 and who is an Illinois resident. To be eligible such veteran must have:
 - a. service in the active or reserve components of the U.S. Armed Forces, including the National Guard;
 - b. received a release or discharge other than a dishonorable discharge; and
 - c. submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." For information on obtaining this form, call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.
5. Your unmarried child who has reached age 26 and who is:
 - a. primarily dependent upon You for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

However, You must give Us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:

1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.]

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:

1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:

1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

[Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:

1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:

1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.]

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:

1. is not eligible for the coverage requested, it will not become effective; or
2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

Incapacitated Child: Coverage of a child who, on the date he or she reaches age [19] or [24], is:

1. covered under the Policy;
 2. mentally or physically incapable of earning his or her own living; and
 3. unmarried and primarily dependent on You for support and maintenance;
- will not terminate solely due to age.

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. [We will send you a bill for the premium due in advance of the due date.] See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony;

BENEFITS

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.]

[IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result of Injuries sustained in a Covered Accident, independent of disease or bodily infirmity.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;
4. the date insurance under the Policy ends.]

[NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

[This benefit is not available to Covered Dependent Children.]

In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or Totally Disabled means, due to an Injury from a Covered Accident, a Covered Person:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and
2. if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.]

[EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the

Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the **Covered Injury**; and
4. the medical expenses are incurred within 52 weeks of the **Covered Injury**.

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

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses

11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
12. X-ray expenses (including reading charges) but not for dental X-rays
13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
15. Ambulance expenses for transportation from the emergency site to the Hospital.
16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
18. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
19. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.
6. Treatment by an Immediate Family Member.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless Medically Necessary for the treatment of the Covered Injury.
9. [All types of hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [Experimental/Investigational treatments or procedures].
11. [A Medical Repatriation.]
12. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
13. Expenses which the Covered Person is not legally obligated to pay.
14. [Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.]

Exclusions: In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
4. Travel outside of the United States of America.
5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.]
17. [being legally intoxicated while operating a motor vehicle.
 - a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.

18. [Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)].

In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

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

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.]

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a

covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay the benefits payable for a valid claim within thirty (30) days after Our receipt of Proof of Loss. If We fail to pay a valid claim within this thirty (30) day period, the amount payable will be increased at a rate of nine percent (9%) per annum until such claim is paid.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to \$1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;
2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right amount expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: We will recognize any assignment You make under the Policy, provided:

1. it is duly executed; and
2. a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.

Extension of Benefits: If coverage under the Policy ends while an Insured Person is totally disabled due to an Accident, We will cover any loss occurring after the date coverage under the Policy ended and for which benefits would have been payable had coverage not ended provided the following conditions are met:

1. the loss must be the result of the same Accident causing the Insured Person to be totally disabled on the date coverage ended; and
2. the loss must occur within 90 days after the date the Insured Person's coverage under this policy ended; and
3. coverage must not have ended as a result of the Insured Person's [or, in the case of a covered Child, the Child's parent's] voluntary termination of the coverage.

This extension of benefits terminates at the end of the 90-day period specified above.

Wesco Insurance Company
Cleveland, OH 44131

**EMERGENCY MEDICAL EVACUATION
BENEFIT RIDER**

THIS RIDER PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES LIMITED SICKNESS COVERAGE. IT IS, THEREFORE, IMPORTANT TO READ THIS RIDER CAREFULLY.

The [Policy] [Certificate] to which this Benefit Rider is attached is amended to include the following benefit:

This Ride is subject to all of the terms and condition of the Policy which are not in conflict with the terms of this Rider.

EMERGENCY MEDICAL EVACUATION EXPENSE COVERAGE

Subject to satisfaction of the Deductible Amount, We will pay the Benefit Amount shown in the Emergency Medical Evacuation Benefit Schedule if a Covered Person requires Emergency Medical Evacuation. Benefits payable are subject to the Benefit Amount shown in the Schedule.

Emergency Medical Evacuation Benefit Schedule	
Benefit Amount:	[\$5,000 - \$50,000]
Deductible Amount:	[\$100 - \$250 per evacuation]
Minimum Number of Miles	[50-200]

A Doctor, in coordination with the assistance company [*insert name of Assistance Company and contact information*], must order the Emergency Medical Evacuation and must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Emergency Medical Evacuation to the closest adequate Hospital for the purpose of stabilizing the Covered Person's condition. It must be determined that such Emergency Medical Evacuation is required due to the inadequacy of local facilities and that the closest adequate Hospital is at least the Minimum Number of Miles shown in the Schedule from where the Covered Person resides.

Exclusions and Limitations: In addition to any appropriate Exclusions and Limitations shown in the Policy, We will not pay for any Emergency Medical Evacuation that is:

- 1) against the advice of a Doctor; or
- 2) for the purpose of obtaining medical care for a condition that is not the result of an Injury or Emergency Sickness.

Definitions: As they relate to this benefit.

Common Carrier means any regularly scheduled land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

Covered Emergency Evacuation Expenses are the usual and customary expenses for necessary Transportation, related medical services and medical supplies incurred in connection with the Emergency Medical Evacuation of an Covered Person. All Transportation arrangements made for evacuating the Covered Person must be by the most direct and economical route possible. Expenses for Transportation must be:

- 1) ordered by the attending Doctor who must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Emergency Medical Evacuation and adequate medical treatment is not locally available;
- 2) required by the standard regulations of the conveyance transporting the Covered Person; and
- 3) authorized in advance by [*add appropriate contact information – Insurer or name authorized representative*]. In the event the Covered Person's Injury or Emergency Sickness prevents prior authorization of the Emergency Medical Evacuation, [*add appropriate contact information*] must be notified as soon as reasonably possible.

Emergency Medical Evacuation means the Covered Person's medical condition warrants immediate transportation from the place where the Covered Person is Injured or Sick to the nearest Hospital where appropriate medical treatment can be obtained.

Emergency Sickness means an illness or disease, diagnosed by a legally licensed Doctor, which meets all of the following criteria:

- 1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Covered Person's condition or place his or her life in jeopardy;
- 2) the severe or acute symptom occurs suddenly and unexpectedly; and
- 3) the severe or acute symptom occurs while coverage is in force.

Transportation means any land, sea or air conveyance required to transport the Covered Person during an Emergency Medical Evacuation. Transportation includes, but is not limited to, Common Carrier, air ambulances, land ambulances and private motor vehicles.

Usual and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the city in which the charge is incurred.

Special Limitation: In the event [*add appropriate contact information*] could not be contacted to arrange for emergency Transportation, benefits are limited to the amount We would have paid had We or Our authorized representation had been contacted.]

In Witness Whereof We Have caused this Rider to be signed by our President and Secretary.



Secretary



President

Wesco Insurance Company

Cleveland, OH 44131

EMERGENCY ROOM BENEFIT RIDER

THIS RIDER PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES LIMITED SICKNESS COVERAGE. IT IS, THEREFORE, IMPORTANT TO READ THIS RIDER CAREFULLY.

The [Policy] [Certificate] to which this Benefit Rider is attached is amended to include the following benefit:

This Rider is subject to all of the terms and condition of the Policy which are not in conflict with the terms of this Rider.

EMERGENCY ROOM COVERAGE

We will pay the Benefit Amount shown in the Emergency Room Benefit Schedule if a Covered Person requires Medically Necessary treatment by a Doctor in a Hospital emergency room for a Medical Emergency due to Injury or Sickness. This benefit will be paid in addition to any other benefits that may be payable under the Policy.

Emergency Room Benefit Schedule	
Benefit Amount:	[\$100-\$1,000] per Visit
Maximum Number of Visits:	[1-5] Visits per Covered Person per Calendar Year

Exclusions and Limitations to: In addition the appropriate Exclusions shown in the Certificate of Coverage, We will not pay for any loss as a result of:

- 1) All types of hernia, however caused,
- 2) Injury or Sickness arising out of or in the course of employment for wage or profit, unless the Covered Person is ineligible for or legally exempt from Workers' Compensation coverage;
- 3) any loss to which a contributing cause was the Covered Person's being engaged in any illegal occupation or activity;
- 4) Injury or Sickness to which a contributing cause was the Insured Person being under the influence of or resulting from the use of intoxicants, including alcohol; or
- 5) related to pregnancy or childbirth; except that Complications of Pregnancy will be covered as any other Sickness;
- 6) any loss to which a contributing cause was the Covered Person's participation as a professional in athletics.

Pre-Existing Conditions Limitation: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following a Covered Person's Effective Date of Coverage under the Group Policy. This limitation will not apply to any loss due to pregnancy.

Definitions: As they relate to this benefit:

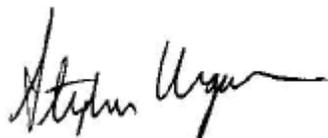
Medical Emergency means the sudden onset of a medical condition for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one that manifests itself by acute symptoms that are sufficiently severe that, without immediate medical attention, could reasonably be expected to result in:

1. placing the Insured Person's health in serious jeopardy;
2. serious impairment of bodily functions; or
3. serious dysfunction of any bodily organ or part.

Medically Necessary means treatment that is prescribed by Your Physician to diagnose or treat an Injury or Sickness, that are known to be safe and effective by the majority of licensed Physicians who diagnose or treat that Injury or Sickness.

Sickness means a sickness, illness or disease which occurs after the effective date of coverage under this certificate and while this certificate is in force. Pregnancy will be considered the same as Sickness under the Policy.

In Witness Whereof We Have caused this Rider to be signed by our President and Secretary.



Secretary



President

FILED

SUBMIT IN DUPLICATE

Date 3-1-01
Filing Fee \$50

Approved Be

http://www.sos.state.il.us

MAR 01 2001

Payment must be made by certified check, cashier's check, Illinois attorney's check, Illinois C.P.A.'s check or money order, payable to "Secretary of State."

DO NOT SEND CASH!

JESSE WHITE
SECRETARY OF STATE

TO: JESSE WHITE, Secretary of State

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986," the undersigned incorporator(s) hereby adopt the following Articles of Incorporation.

Article 1. The name of the corporation is: National Internet Consumers Association

Article 2. The name and address of the initial registered agent and registered office are:

Registered Agent CT CORPORATION SYSTEM
 First Name Middle Name Last Name
 Registered Office 208 S. LASALLE
 Number Street (Do not use P.O. Box)
CHICAGO IL 60604 COOK
 City ZIP Code County

Article 3: The first Board of Directors shall be 3 in number, their names and residential addresses being as follows: (Not less than three)

Director's Names	Number	Street	Address City	State
Gary Johnston	2544	Christopher Oaks Ct.	St. Louis, MO	63129
Karen Boeker	13	Bordeaux Place	Lake St. Louis, MO	63367
Tracy MacIntosh	2720	Sunny Meadows Dr.	St. Charles, MO	63303

Article 4. The purposes for which the corporation is organized are:

Educational

Is this corporation a Condominium Association as established under the Condominium Property Act?
 Yes No (Check one)

Is this corporation a Cooperative Housing Corporation as defined in Section 216 of the Internal Revenue Code of 1954? Yes No (Check one)

Is this a Homeowner's Association which administers a common-interest community as defined in subsection (c) of Section 9-102 of the code of Civil Procedure? Yes No

Article 5. Other provisions (please use separate page):

NAMES & ADDRESSES OF INCORPORATORS

The undersigned incorporator(s) hereby declare(s), under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true.

Dated January 2001 (Month & Day) (Year)

SIGNATURES AND NAMES
1. Signature: Gary Johnston
2. Signature: Karen Boeker
3. Signature:
4. Signature:
5. Signature:

POST OFFICE ADDRESS
1. Street: 2544 Christopher Oaks Ct.
City/Town: St. Louis, MO 63129
2. Street: 13 Bordeaux Place
City/Town: Lake St. Louis, MO 63367
3. Street:
4. Street:
5. Street:

(Signatures must be in BLACK INK on original document. Carbon copied, photocopied or rubber stamped signatures may only be used on the true copy.)

- If a corporation acts as incorporator, the name of the corporation and the state of incorporation shall be shown and the execution shall be by its President or Vice-President and verified by him, and attested by its Secretary or an Assistant Secretary.
• The registered agent cannot be the corporation itself.
• The registered agent may be an individual, resident in this State, or a domestic or foreign corporation, authorized to act as a registered agent.
• The registered office may be, but need not be, the same as its principal office.
• A corporation which is to function as a club, as defined in Section 1-3.24 of the "Liquor Control Act" of 1934, must insert in its purpose clause a statement that it will comply with the State and local laws and ordinances relating to alcoholic liquors.

FOR INSERTS - USE WHITE PAPER - SIZE 8 1/2 x 11

File No.
FORM NFP-102.10
ARTICLES OF INCORPORATION
under the
GENERAL NOT FOR PROFIT
CORPORATION ACT
of

SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
SPRINGFIELD, ILLINOIS 62756
TELEPHONE (217) 782-9522
782-9523
(These Articles Must Be Executed and Filed in Duplicate)

Filing Fee \$50
C-157.11

NFP-110.30
(Rev. Jan. 1999)

JESSE WHITE
Secretary of State
State of Illinois

File # N6152.376.6

Submit in Duplicate
Remit payment in check or money
order, payable to "Secretary of
State."

DO NOT SEND CASH!

ARTICLES OF AMENDMENT
under the
GENERAL NOT FOR PROFIT
CORPORATION ACT

This Space For Use By Secretary of State	
Date	<u>5/2/03</u>
Filing Fee	\$25.00
Approved	<i>He</i>

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986," the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is National Internet
Consumers Association (Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on 4-21,
2003 in the manner indicated below ("X" one box only.) (Month & Day)
(Year)

- By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)
- By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)
- By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)
- By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 5)

(INSERT RESOLUTION)

BE IT HEREBY RESOLVED, the name of the corporation shall be changed to read: "National Association of Consumers Direct" and the Articles of Incorporation shall be amended at Article One (1) to reflect the change of name.

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalties of perjury, that the facts stated herein are true. (All signatures must be in **BLACK INK.**)

Dated April 22, 2003 National Internet Consumers Association
 (Month & Day) (Year) (Exact Name of Corporation)
 attested by Karen Becker by Monica Roy
 (Signature of Secretary or Assistant Secretary) (Signature of President or Vice President)
Karen Becker, Secretary Monica Roy, President
 (Type or Print Name and Title) (Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1:** State the true exact corporate name as it appears on the records of the Office of the Secretary of State, **BEFORE** any amendments herein reported.
- NOTE 2:** Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3:** Director approval may be (1) by vote at a director's meeting (*either annual or special*) or (2) consent, in writing, without a meeting.
- NOTE 4:** All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.

Member approval may be (1) by vote at a members meeting (*either annual or special*) or (2) by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (*but if class voting applies, then also at least a 2/3 vote within each class is required*).

The articles of incorporation may supersede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (Sec. 110.20)

- NOTE 5:** When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No.

ARTICLES OF AMENDMENT
 under the
 GENERAL NOT FOR PROFIT
 CORPORATION ACT

Filing Fee \$25

FILED

MAY 2 - 2003

JESSE WHITE
SECRETARY OF STATE

RETURN TO:

Department of Business Services
 Secretary of State
 Springfield, Illinois 62756
 Telephone (217) 782-1832
<http://www.sos.state.il.us>

C-130.10

AMENDED BY-LAWS OF
NATIONAL ASSOCIATION OF CONSUMERS DIRECT

ARTICLE I
PURPOSES

The purpose of the NATIONAL ASSOCIATION OF CONSUMERS DIRECT (the “Association”) shall be: “educational” as stated in the Certificate of Incorporation, as well as any powers as are now or may hereafter be granted by the General Not-For-Profit Law of the State of Illinois. The purpose of the association shall be further stated as providing consumer-related educational resources and access to affordable consumer benefits, products and services by leveraging the Association’s group purchasing power.

The term ‘consumer-related educational resources’ may include, but not be limited to, periodic hard copy or electronic newsletters providing consumer spending news, recall and scam alerts, and information on controlling personal finances. The term ‘affordable consumer benefits, products and services’ may include, but not be limited to, insured programs, identity theft assistance services, travel assistance services, roadside assistance services, and Association-negotiated discounts on lifestyle services.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Illinois as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in membership programs offered by the Association.

2. Family membership: The member and his or her spouse and dependent children are entitled to participate in membership programs offered by the Association. The term spouse shall be defined as the primary member’s legal spouse and domestic partners where a domestic partnership is authorized by law.

The Board of Directors may, by Board Resolution, create sub-classes of membership with participation restrictions based upon individual or family membership option limits, working status or age.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV **MEETINGS OF MEMBERS**

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place within or without the State of Illinois as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Illinois as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally or

by mail, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;
2. The election of the Board of Directors; and
3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and be members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Illinois for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally or sent by mail to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause,

by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI **OFFICERS**

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII **COMMITTEES**

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII **CONTRACTS, CHECKS, DEPOSITS, AND FUNDS**

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such

determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX

CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X

BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI

DUES AND INITIATION FEE

Section 1. Dues. The Board of Directors may determine from time to time the amount of dues payable to the Association by members of each class or sub-class, as applicable.

Section 2. Payment of Dues. Dues shall be payable in advance of the date of membership.

Section 3. Default and Termination of Membership. When any member of any class or sub-class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII **FISCAL YEAR**

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII **SEAL**

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV **WAIVER OF NOTICE**

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Illinois under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV **AMENDMENT OF BY-LAWS**

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting,

provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

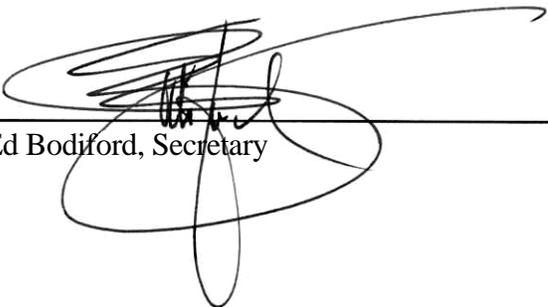
ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

Adopted this 28th day of April, 2009 by unanimous consent of the Board of Directors of National Association of Consumers Direct at a special meeting of the Board of Directors.



Ed Bodiford, Secretary

SERFF Tracking #:

UNKP-128719102

State Tracking #:**Company Tracking #:**

AH990017 NACD

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Single Case LB Association Filing - NACD

Project Name/Number:

NACD Single-Case LB Association Filing/AH990017 - NACD

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/08/2012	Replaced 10/26/2012	Form	Limited Benefits Certificate	10/24/2012	WIC-AH-AD-CERT (0312) NACD AR (20121009 cc).pdf (Superseded)

**Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038**

Policyholder: National Association of Consumer Direct

Policy Number: NACD1234567

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

Table of Contents
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Premiums
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Benefits
Claims

Group Limited Benefits Certificate of Coverage

THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS CERTIFICATE CAREFULLY.

Signed for Wesco Insurance Company



President



Secretary

NEED ASSISTANCE? If you have a question or wish to obtain information about Your coverage, or You require assistance in resolving a complaint, please contact us at 1-800-215-7265.

GENERAL DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

Confined and Confinement mean:

1. being admitted to a Hospital for receiving inpatient hospital services; and
2. the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.
3. Not one of the following:
 - a. A person who ordinarily resides in Your household
 - b. A member of Your immediate family
 - c. The Policyholder.

Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner are not legally married to anyone else.

Hospital means an institution which:

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

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

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.†

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident and independently of all other causes which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2. medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or Insured Person means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
 - a. cease to be an Eligible Person;
 - b. attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
 - c. fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

1. are not eligible for the coverage requested, the change will not become effective;
2. are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:

1. **Spouse** means Your spouse [or Domestic Partner] unless:
 - a. You and Your spouse are legally separated or divorced [the domestic partnership is dissolved]; or
 - b. He or she has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means Your unmarried child, stepchild, legally adopted child from the date of placement, or foster child:

- a. who is less than age 19 and primarily dependent on You for support and maintenance; or
- b. under the age of 26 if a resident of Florida who is enrolled as full or part-time student at an institution of learning and primarily dependent on You for support and maintenance.

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:

1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:

1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:

1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:

1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:

1. is not eligible for the coverage requested, it will not become effective; or

2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

Incapacitated Child: Coverage of a child who, on the date he or she reaches age 19 or 26, is:

1. covered under the Policy;
 2. mentally or physically incapable of earning his or her own living; and
 3. unmarried and primarily dependent on You for support and maintenance;
- will not terminate solely due to age.

However, You must give Us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:

1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.}

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony;

BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.

IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result, from no other causes, of Injuries sustained in a Covered Accident.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;

4. the date insurance under the Policy ends.}

NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion: In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

This benefit is not available to Covered Dependent Children.

Definitions: In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or Totally Disabled means during the first twelve (12) months that You are unable to perform the material and substantial duties of Your regular occupation. After the first twelve (12) months, Total Disability means You are unable to perform any work or occupation for which You are reasonably qualified or trained.

EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the Covered Injury; and
4. the medical expenses are incurred within 52 weeks of the Covered Injury.

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

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses

11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
 12. X-ray expenses (including reading charges) but not for dental X-rays
 13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
 14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
 15. Ambulance expenses for transportation from the emergency site to the Hospital.
 16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
 17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
 18. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
 19. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.
- Exclusions:** In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:
1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
 2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
 3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
 4. Travel outside of the United States of America.
 5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
 6. Treatment by an Immediate Family Member.
 7. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.
 8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless

Medically Necessary for the treatment of the Covered Injury.

9. A hernia.
10. Routine physical examinations and related medical services or elective treatment or surgery or Experimental/Investigational treatments or procedures.
11. A Medical Repatriation.
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the Covered Person is not legally obligated to pay.
14. Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.
15. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.
16. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.
17. being legally intoxicated while operating a motor vehicle.
 - a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.
18. Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.).

Definitions: In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

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

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1. on a monthly basis, after We receive the proof of loss, while the loss and liability continue; or
2. immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to \$1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;

2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right, at our expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: The group policy is non-assignable. You may not assign any of the Policyholder's rights or privileges under the Policy. However, You may assign the benefit to which You are entitled to a provider of services. If an irrevocable beneficiary has been designated, that person must give written consent to any assignment. No assignment will be binding on Us unless it is in writing and a copy is sent to Us. We accept no responsibility for the validity of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.