

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Filing at a Glance

Company: Wesco Insurance Company
Product Name: Group Limited Benefits Insurance Program
State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
Filing Type: Form
Date Submitted: 08/02/2012
SERFF Tr Num: UNKP-128614623
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AH990017LB
Implementation: On Approval
Date Requested:
Author(s): Susan Coulter
Reviewer(s): Donna Lambert (primary)
Disposition Date: 12/03/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Wesco Insurance Company
 TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
 Product Name: Group Limited Benefits Insurance Program
 Project Name/Number: Group Limited Benefits Filing/AH990017LB

General Information

Project Name: Group Limited Benefits Filing Status of Filing in Domicile: Authorized
 Project Number: AH990017LB Date Approved in Domicile: 03/08/2012
 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: Employer Overall Rate Impact:
 Filing Status Changed: 12/03/2012 Deemer Date:
 State Status Changed: 12/03/2012 Submitted By: Susan Coulter
 Created By: Susan Coulter
 Corresponding Filing Tracking Number:

Filing Description:
 AH990017 (0312) Group Limited Benefits Policy
 AH990018 AR Amendatory Endorsement
 WIC-AH-AD-APP (0312) Group Application
 WIC-AH-AD-CERT (0312) Group Limited Benefits Certificate of Coverage
 WIC-AH-AD-SCHED (0312) Schedule of Benefits
 WIC RIDER ER Optional Emergency Room Benefit Rider
 WIC RIDER EME Optional Emergency Medical Evacuation Benefit Rider
 AH-PN-01-AR Consumer Information Notice

On behalf of Wesco Insurance Company we are filing the attached group limited benefit forms for your review and approval. The forms will be marketed to eligible employer groups in your state.

Under policy form AH990017 (0312) there are four benefits available including accidental death and dismemberment, accident hospital indemnity, accident short-term disability, and accident medical expense. Either the accidental death and dismemberment benefit and/or the accident hospital indemnity benefit will always be provided. The policyholder may also select to provide the accident short term disability or the accident medical expense. Dependents coverage is available.

In addition to the basic policy benefits, the Company will make available two optional benefit riders. Rider form WIC RIDER ER is designed to provide benefits when an insured utilizes an emergency room as a result of an accidental injury or emergency sickness. Rider form WIC RIDER EME is designed to provide an insured emergency transportation to the closest adequate hospital when local facilities are inadequate and the closest adequate hospital is at least a specified number of miles from where the insured has become injured or suffers an emergency sickness.

A policyholder will use group application form WIC-AH-AD-APP (0312) when applying for coverage under the policy.

Eligible members of the policyholder will be covered on a non-medical basis. Certificate form WIC-AH-AD-CERT (0312) will be issued to each enrolling member as proof of coverage. Benefit schedule form WIC-AH-AD-SCHED (0312) will be completed based upon the plan specifications agreed upon by the policyholder and the Company and attached to each certificate issued under the policy.

Amendatory rider form AH990018 AR will be attached to the policy and certificate at time of issue. This rider modifies the policy/certificate to comply with Arkansas requirements.

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Consumer Information Notice form AH-PN-01-AR will also be attached to each policy and certificate at the time of issue.

These are new forms for Wesco Insurance Company and will not replace any forms on file in your state.

Please do not hesitate to contact us at (609) 443-7540 or by email at frank@coulter-and-associates.com 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

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: \$450.00
 Retaliatory? No
 Fee Explanation: AR fee \$50 per form x 8 forms (\$400) + \$50 for rates = \$450.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
Wesco Insurance Company	\$450.00	08/02/2012	61386208

SERFF Tracking #:

UNKP-128614623

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

AH990017LB

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment

Product Name:

Group Limited Benefits Insurance Program

Project Name/Number:

Group Limited Benefits Filing/AH990017LB

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/03/2012	12/03/2012
Approved	Donna Lambert	08/07/2012	08/07/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Limited Benefits Certificate	Susan Coulter	11/28/2012	11/28/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Reopened	Note To Filer	Donna Lambert	11/28/2012	11/28/2012

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Disposition

Disposition Date: 12/03/2012

Implementation Date:

Status: Approved

Comment: Pursuant to our telephone conversation, the policy is approved with the correct form number and no other changes have been made. I understand the form has not yet been marketed.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Wesco Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statements of Variability	Accepted for Informational Purposes	Yes
Supporting Document	Filing Authorization		Yes
Form	Group Limited Benefits Policy	Approved	Yes
Form (revised)	Group Limited Benefits Certificate	Approved	Yes
Form	Group Limited Benefits Certificate	Replaced	Yes
Form	Schedule of Benefits	Approved	Yes
Form	Group Application	Approved	Yes
Form	Emergency Room Benefit Rider	Approved	Yes
Form	Emergency Medical Evacuation Rider	Approved	Yes
Form	Amendatory Endorsement	Approved	Yes

SERFF Tracking #:

UNKP-128614623

State Tracking #:

Company Tracking #:

AH990017LB

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment

Product Name:

Group Limited Benefits Insurance Program

Project Name/Number:

Group Limited Benefits Filing/AH990017LB

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Consumer Information Notice	Approved	Yes

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Disposition

Disposition Date: 08/07/2012

Implementation Date:

Status: Approved

Comment: The format of your Statement of Variables is wonderful!

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Wesco Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statements of Variability	Accepted for Informational Purposes	Yes
Supporting Document	Filing Authorization		Yes
Form	Group Limited Benefits Policy	Approved	Yes
Form (revised)	Group Limited Benefits Certificate	Approved	Yes
Form	Group Limited Benefits Certificate	Replaced	Yes
Form	Schedule of Benefits	Approved	Yes
Form	Group Application	Approved	Yes
Form	Emergency Room Benefit Rider	Approved	Yes
Form	Emergency Medical Evacuation Rider	Approved	Yes
Form	Amendatory Endorsement	Approved	Yes
Form	Consumer Information Notice	Approved	Yes

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Amendment Letter

Submitted Date: 11/28/2012

Comments:

Attached is a revised version of the Group Limited Benefits Certificate Form Number: WIC-AH-AD-CERT (0312). Please update the filing accordingly.

Thank you for your guidance.

Changed Items:

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	Group Limited Benefits Certificate	WIC-AH-AD-CERT (0312)	CER	Initial		50.600	WIC-AH-AD-CERT (0312).pdf	Date Submitted: 11/28/2012 By:
<i>Previous Version</i>								
1	Group Limited Benefits Certificate	WIC-AH-AD-CERT (0312)	CER	Initial		50.600	WIC-AH-AD-CERT (0312).pdf	Date Submitted: 08/02/2012 By: Susan Coulter

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Note To Filer

Created By:

Donna Lambert on 11/28/2012 11:57 AM

Last Edited By:

Donna Lambert

Submitted On:

11/28/2012 11:58 AM

Subject:

Reopened

Comments:

The filing is reopened so you can attach a certificate with the correct form number. As long as the certificate has not been used or any revisions have been made, I will allow the certificate with the correct form number to have the approval date of 8/7/12.

This is in reference to your response to the objection on filing UNKP-128746354, an association filing using the same certificate (with a revised form number to indicate it will be used with an association).

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Form Schedule

Lead Form Number: AH990017 (0312)								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 08/07/2012	Group Limited Benefits Policy	AH990017 (0312)	POL	Initial		51.100	AH990017 (0312) - LB GROUP POLICY.pdf
2	Approved 12/03/2012	Group Limited Benefits Certificate	WIC-AH-AD-CERT (0312)	CER	Initial		50.600	WIC-AH-AD-CERT (0312).pdf
3	Approved 08/07/2012	Schedule of Benefits	WIC-AH-AD-SCHED (0312)	SCH	Initial		58.000	WIC-AH-AD-SCHED (0312) (20120319 cc).pdf
4	Approved 08/07/2012	Group Application	WIC-AH-AD-APP (0312)	AEF	Initial		48.200	WIC-AH-AD-APP (0312) (20120319 cc).pdf
5	Approved 08/07/2012	Emergency Room Benefit Rider	WIC RIDER ER	POLA	Initial		52.400	WIC Rider ER (20120319 cc).pdf
6	Approved 08/07/2012	Emergency Medical Evacuation Rider	WIC RIDER EME	POLA	Initial		52.100	WIC Rider EME (20120319 cc).pdf
7	Approved 08/07/2012	Amendatory Endorsement	AH990018 AR	POLA	Initial		53.800	AH990018 AR - Endorsement (20120802 cc).pdf
8	Approved 08/07/2012	Consumer Information Notice	AH-PN-01-AR	OTH	Initial			AH-PN-01-AR - Consumer Information Notice.pdf

SERFF Tracking #:

UNKP-128614623

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

AH990017LB

State:

Arkansas

Filing Company:

Wesco Insurance Company

TOI/Sub-TOI:

H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment

Product Name:

Group Limited Benefits Insurance Program

Project Name/Number:

Group Limited Benefits Filing/AH990017LB

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

GROUP LIMITED BENEFITS INSURANCE POLICY

Policyholder Name:

Policy Number:

Policyholder Address:

Place of Delivery:

Policy Effective Date:

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 ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS POLICY CAREFULLY.]

[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.

Form

Applicable To

Effective Date of
Incorporation

Certificate of Insurance Form
Rider Form

All Eligible Persons

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

Policyholder: ABC, Inc.

Policy Number: ABC1234567

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

Group Limited Benefits Certificate of Coverage

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

[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

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.

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, [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:

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.

[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:

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, or foster child:
 - a. who is less than age [19] and primarily dependent on You for support and maintenance; or
 - b. who is at least age [19] but less than age [24] who:
 - i. regularly attends an institution of learning; and
 - ii. is 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 [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.

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. [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, 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.]

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.

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: 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.

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

SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy.

Policyholder: [Group Name]
Policy Effective Date: [January 1, 2008]
Policy Number: [12345678]
Policyholder Address: [Address]

Insured Person: [name]
Certificate Effective Date: [January 1, 2007]
Covered Dependents [named Spouse[, Domestic Partner] [and children]
[Covered Dependents Effective Date: [January 1, 2007]]
Frequency of Premium Payment: [Monthly, Quarterly, Semi-annually, Annually]
Method of Premium Payment: [Remitted by Policyholder] [Remitted by Insured Person To Us]
Premium Due Date: [1st thru 31st]

Policy Age Limit for You and Your Covered Spouse [Domestic Partner] [None-100]

BENEFITS

[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 as an Insured Person's Dependent is calculated by applying the percent, determined below, to the Insured Person's Principal Sum.

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

[Emergency Room Benefit (Rider Form WIC RIDER ER):

Benefit Amount per Covered Person per Visit: [\$100-\$1,000]

Maximum Number of Visits per Covered Person per Calendar Year: [1-5] Visits]

[Emergency Medical Evacuation Benefit (Rider Form WIC RIDER EME):

Benefit Amount: [\$5,000-\$50,000]

Deductible Amount: [\$100-\$250] per Evacuation

Minimum Number of Miles: [100-200]]

**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: [XXXX-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 Accident and Sickness Benefit (Rider Form WIC RIDER ER):

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

Emergency Medical Evacuation Benefit (Rider Form WIC RIDER EME):

Benefit Amount: [\$5,000-\$50,000]
Deductible Amount: [\$100-\$250] per Evacuation
Minimum Number of Miles: [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.

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance

company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(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.

(Maine) 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 denial of insurance benefit.

(Maryland/Rhode Island) 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.

(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.

(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.

(Virginia) Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

(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.

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]**

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;
- 5) pregnancy or childbirth; except that Complications of Pregnancy will be covered as any other Sickness; or
- 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.

Definitions: As they relate to this benefit:

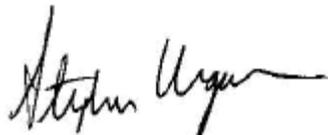
Medical Emergency means the sudden onset of a medical condition for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one that manifests itself by acute symptoms that are sufficiently severe that, without immediate medical attention, could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

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 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

[POLICY][CERTIFICATE] AMENDATORY ENDORSEMENT

The [Policy][Certificate] to which this endorsement is attached is amended as follows:

1) The following provisions are added:

Newborn Children's Coverage: A child born to You while this Policy is in force will be covered from the moment of birth. A notice of birth, together with the additional premium, must be submitted to Us within 90 days of birth or before the next premium due date, whichever is later, in order to continue coverage.

Adopted Children's Coverage: A minor child who comes under the charge, care and control of the Insured while this Policy is in force is covered, provided You file a petition to adopt. The coverage of such child will be the same as provided for other member's of Your family. Such child will be covered from the date the petition to adopt is filed if You apply for coverage and pay any required premium within 60 days after the filing the petition to adopt. However, coverage will begin at the moment of birth if the petition for adoption is filed within 60 days after the child's birth. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

2) The provision entitled **Incapacitated Child** is hereby deleted and the following provision is added:

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.

Coverage will continue as long as:

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

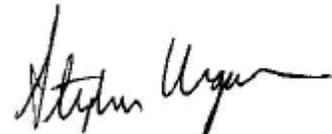
At our request and expense, proof of the child's incapacity and dependency must be furnished to us by the Insured. If the incapacity or dependency subsequently ends, the Insured must notify us.

There are no other changes to the Policy.

Signed for the Company



President



Secretary

CONSUMER INFORMATION NOTICE

Questions regarding your Policy or coverage should be directed to:

Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038
1 (800) 234 5678

If We fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Divisions
1200 West Third Street
Little Rock, Arkansas 72201
1 (800) 852 5494 or (501) 371-2640

SERFF Tracking #:

UNKP-128614623

State Tracking #:

Company Tracking #:

AH990017LB

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Rate Information

Rate data applies to filing.

Filing Method: Review and Approval
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 01/01/1001
Filing Method of Last Filing: None

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Wesco Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

UNKP-128614623

State Tracking #:

Company Tracking #:

AH990017LB

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H03G Group Health - Accidental Death & Dismemberment/H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Limited Benefits Insurance Program
Project Name/Number: Group Limited Benefits Filing/AH990017LB

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR LB Flesch Certification.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	N/A - New app attached under Form Schedule tab being submitted for approval.		

		Item Status:	Status Date:
Satisfied - Item:	Statements of Variability	Accepted for Informational Purposes	08/07/2012
Comments:			
Attachment(s):			
AH990017 (0312) - LB GROUP POLICY SOVL.pdf WIC Rider EME (20120319 SOV).pdf WIC-AH-AD-CERT (0312) SOVL.pdf WIC-AH-AD-SCHED (0312) (20120319 SOV).pdf WIC Rider ER (20120319 SOV).pdf WIC-AH-AD-APP (0312) (20120319 SOV).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Filing Authorization		
Comments:			
Attachment(s):			
Wesco LB Filing Authorization 2012.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
AH990017 (0312)	Group policy	51.5
AH990018 AR	Amendatory Endorsement	53.9
WIC-AH-AD-CERT (0312)	Group Certificate	50.6
WIC-AH-AD-APP (0312)	Group Application	48.2
WIC-AH-AD-SCHED (0312)	Schedule	58.0
WIC RIDER ER	Emergency Room Benefit Rider	52.4
WIC RIDER EME	Emergency Medical Evacuation Benefit Rider	52.1

Signature of Office:  _____

Title: Vice President, Regulatory Compliance

Date: 8/2/2012

STATEMENT OF VARIABLES

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

GROUP LIMITED BENEFITS INSURANCE POLICY

Policyholder Name:

Policy Number:

Policyholder Address:

Place of Delivery:

Policy Effective Date:

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 ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS POLICY CAREFULLY.] ← Show this disclosure statement if accident-only benefits provided.

[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.] ← Show this disclosure statement if WIC RIDER ER and/or WIC RIDER EME attached.

TABLE OF CONTENTS

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

STATEMENT OF VARIABLES

SCHEDULE OF ELIGIBLE PERSONS

ELIGIBLE PERSONS:

ELIGIBLE MEMBER:

Included for associations [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.]

Included for employers [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 *included if eligible* [Domestic Partner] and Child(ren)
An Eligible Spouse *included if eligible* [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 *included if eligible* [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 *included if eligible* [Domestic Partner], but not both.

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

POLICY AGE LIMIT: [None-100]

EVIDENCE OF INSURABILITY: None

Eligibility Waiting Period: *included if Policyholder requests specific eligibility – will reflect language to support request [as determined by the Policyholder from the first day of eligibility]*
Included for employers [1-60 Days] [1-3 Months] from the first day of Active Work]
Included for associations [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] *or* [Remitted by Insured Person To Us]

STATEMENT OF VARIABLES

SCHEDULE OF BENEFITS

ADD or Accident Hospital Indemnity always selected

BENEFITS AND AMOUNTS:

Included if selected by policyholder **[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%.] *included or deleted*

[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%.]

included or deleted

[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.] *included or deleted*

Included if selected by policyholder **[Accident Hospital Indemnity Benefit for all Covered Persons:**

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

]

Included if selected by policyholder **[Non-Occupational Weekly Disability Income Benefits for Insured Person Only**

Weekly Disability Benefit: [\$100 - \$2,000] 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.]]

]

Included if selected by policyholder **[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]

]

STATEMENT OF VARIABLES

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 AH990017 (0312)

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.

STATEMENT OF VARIABLES

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.

Form

Applicable To

Effective Date of
Incorporation

Certificate of Insurance Form
Rider Form

All Eligible Persons

STATEMENT OF VARIABLES

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 *either* [Policy] *or* [Certificate] *will be shown depending upon base document to which rider is attached.* 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.

STATEMENT OF VARIABLES

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

[↑Names and signatures will change as Secretary and President are changed.↑](#)

STATEMENT OF VARIABLES

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

Policyholder:

Policy Number:

Either Accidental Death and Dismemberment or Accident Hospital Indemnity/Cash benefit will always be issued. Short term disability and accident medical expense are optional benefits.

We have issued a Policy to the Policyholder named above for the benefit of *either* [members] *or* [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
Definitions
Insured Person Period of Coverage
[Insured Dependent Period of Coverage] <i>Included if dependents covered</i>
Premiums
General Exclusions
Benefits
Claims

Group Limited Benefits Certificate of Coverage

[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS CERTIFICATE CAREFULLY.] *Use this disclosure if accident-only benefits provided.*

[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.] *Use this disclosure if ER and/or EME riders attached.*

Signed for Wesco Insurance Company



President



Secretary

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.

Included if employer group and active work standard imposed
[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

STATEMENT OF VARIABLES

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.

Included if hospital indemnity included or deferred effective date language imposed **[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.

Included if dependents covered and domestic partners covered

[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.]

Included if hospital indemnity included or deferred effective date language imposed **[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.

STATEMENT OF VARIABLES

If You are Confined in a Hospital on the date Your insurance would otherwise become effective, Your effective date will be deferred until You are no longer so Confined.

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.

Included if dependents covered [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, or foster child:
 - a) who is less than age [19] and primarily dependent on You for support and maintenance; or
 - b) who is at least age [19] but less than age [24] who:
 - 1) regularly attends an institution of learning; and
 - 2) is 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.

Included or deleted [If an Eligible Dependent is Confined in a Hospital on the date insurance would otherwise go into effect, We will defer the effective date until such date that the Dependent is no longer confined.]

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.

Included or deleted based on state requirements [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.

STATEMENT OF VARIABLES

Included if Dependents Coverage is in effect **[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.

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. *Included for associations – direct bill* [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

If selected by policyholder **[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.

Some combination of the following perils

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.]

If selected by policyholder **[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

STATEMENT OF VARIABLES

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.]

If selected by policyholder **[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.] *Included if dependents covered and children eligible for benefit*

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.]

If selected by policyholder **[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.

STATEMENT OF VARIABLES

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, massage 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.] *Included or deleted*
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.] *Included or deleted*
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [Experimental/Investigational treatments or procedures]. *Included or deleted*
11. [A Medical Repatriation.] *Included or deleted*
12. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.] *Included or deleted*
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.] *Included or deleted*
15. [Expenses related to the repair or replacement of existing artificial limbs,

STATEMENT OF VARIABLES

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.] *Included or deleted*

16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.] *Included or deleted*
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.] *Included or deleted*
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.).] *Included or deleted*

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.

STATEMENT OF VARIABLES

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 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.

STATEMENT OF VARIABLES

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.

STATEMENT OF VARIABLES

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

SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy.

Policyholder: [Group Name] ← *Actual policyholder name will be shown.*

Policy Effective Date: [January 1, 2008] ← *Actual policy effective date will be shown.*

Policy Number: [12345678] ← *Actual policy number will be shown.*

Policyholder Address: [Address] ← *Actual policyholder address will be shown.*

Insured Person: [name] ← *Actual name of principal insured will be shown.*

Certificate Effective Date: [January 1, 2007] ← *Actual certificate effective date will be shown.*

Covered Dependents [named Spouse *or* Domestic Partner *and/or* children *shown here.*]

[Covered Dependents Effective Date: [January 1, 2007]] ← *Covered dependents effective date shown if other than certificate effective date.*

Frequency of Premium Payment: [Monthly *or* Quarterly *or* Semi-annually *or* Annually]

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

Premium Due Date: [1st thru 31st] ← *Premium due date will be shown.*

Policy Age Limit for You and Your Covered Spouse [Domestic Partner] [None-100]

BENEFITS

[Accidental Death and Dismemberment Benefit ← *This benefit included at the option of the policyholder.*

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 as an Insured Person's Dependent is calculated by applying the percent, determined below, to the Insured Person's Principal Sum.

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

*As determined on the date of accident]

STATEMENT OF VARIABLES

[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%.]← *This benefit included or deleted at the option of the policyholder.*

[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%.]← *This provision included or deleted at the election of the policyholder.*

[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.]← *This provision included only if policy is non-contributory; will be deleted if this is a contributory policy.*

[Accident Hospital Indemnity Benefit for all Covered Persons:

Daily Hospital Confinement Benefit Amount: [\$30-\$500]

Maximum Benefit Period: [30-365] Days Per Confinement]← *This benefit included or deleted at the election of the policyholder.*

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

Weekly Disability Benefit: [\$100 - \$2,000] 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.]]← *This benefit included or deleted at the election of the policyholder.*

[Accident Excess Medical Expense Benefit for all Covered Persons:

Deductible: [\$100-\$200 per Certificate Year]

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]]← *This benefit included or deleted at the election of the policyholder.*

[Emergency Room Benefit (Rider Form WIC RIDER ER):

Benefit Amount per Covered Person per Visit: [\$100-\$1,000]

Maximum Number of Visits per Covered Person per Calendar Year: [1-5] Visits]← *This benefit included or deleted at the election of the policyholder.*

[Emergency Medical Evacuation Benefit (Rider Form WIC RIDER EME):

Benefit Amount: [\$5,000-\$50,000]

Deductible Amount: [\$100-\$250] per Evacuation

Minimum Number of Miles: [100-200]]← *This benefit included or deleted at the election of the policyholder.*

STATEMENT OF VARIABLE

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 *either* [Policy] *or* [Certificate] *will be shown depending upon base document to which rider is attached.* 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;
- 5) pregnancy or childbirth; except that Complications of Pregnancy will be covered as any other Sickness; or
- 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.

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.

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



Secretary



President

[↑ Names and signatures will change as Secretary and President are changed. ↑](#)

STATEMENT OF VARIABLES

**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]				
<i>Included if it is a takeover</i> →[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_____]				

All references to Dependents and/or Domestic Partners are included if Dependents and/or Domestic Partner Coverage is in effect:

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]← <i>Included for associations</i> <input type="checkbox"/> Actively at work employees working _____ hours per week.]← <i>Included for employers</i> <input type="checkbox"/> Persons who become Members after the Policy Effective Date] <i>Included or deleted</i> →[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%

STATEMENT OF VARIABLES

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 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: [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]

Emergency Room Accident and Sickness Benefit (Rider Form WIC RIDER ER):

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

Emergency Medical Evacuation Benefit (Rider Form WIC RIDER EME):

Benefit Amount: [\$5,000-\$50,000]
Deductible Amount: [\$100-\$250] per Evacuation
Minimum Number of Miles: [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.]<included or deleted
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.]<included or deleted
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.]<included or deleted
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.]<included or deleted

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]<included or deleted; and
4. to notify all Insured Persons of any termination or rescission of coverage which affects them and refund the appropriate premium.]<included or deleted

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.

STATEMENT OF VARIABLES

(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.

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(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/Rhode Island) 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.

(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.

(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.

(Virginia) Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

(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.

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

STATEMENT OF VARIABLES

[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]**



Wesco Insurance Company
An AmTrust Financial Company

January 2, 2012

To: Various Departments of Insurance

Re: Authorization to Represent Wesco Insurance Company

Wesco Insurance Company
NAIC # 25011
FEIN # 85-0165753
Letter of Authorization
Filing of Forms, Rates & Rules

Dear Sir or Madam:

This letter, or a copy thereof, will authorize the consulting firm of Coulter & Associates of Cranbury, New Jersey, to represent Wesco Insurance Company before your Insurance Department solely with respect to matters concerning filing for approval of Wesco Insurance Company's Group Limited Benefits Program and associated premium rates.

This authorization will remain in effect until revoked in writing by Wesco Insurance Company.

Please direct any correspondence in relation to this filing to Coulter & Associates 379 Princeton-Hightstown Road, Cranbury, NJ 08512, (609) 443-7540, or by e-mail to susan@coulter-and-associates.com.

The contact person with Wesco Insurance Company is Karen Owsiany, 500 Enterprise Dr., Suite 3C, Rocky Hill, CT 06067. Ms. Owsiany can be reached by phone at (860) 571-2160 or by e-mail at karen.owsiany@amtrustgroup.com.

Sincerely,

Karen Owsiany
AVP, Regulatory & Compliance