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The following provisions appear within this Policy in the following order:

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	**52 weeks from the date of the Covered Injury**
CLASS OF ELIGIBLE PERSONS:	**Class 1:** Eligible students of the Policyholder who have been assigned an NCC-ID number, including Policyholder intercollegiate student athletes, student managers and student coaches participating in Men's Baseball, Men's and Women's Basketball, Men's and Women's Cheerleading, Men's and Women's Cross Country, Women's Dance, Men's Football, Men's and

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	**100% of the Semi-Private Room Rate**
Intensive Care/Cardiac Care Room & Board:	**100% of URC**
Hospital Miscellaneous Benefit:	**100% of URC**
Pre-Admission Testing Benefit:	**100% of URC**
In-Patient Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	**100% of URC**
Assistant Surgeon Benefit:	**100% of URC**
Out-Patient Surgery Benefits:	
Outpatient Primary Surgeons Maximum Benefit Amount:	**100% of URC**
Outpatient Assistant Surgeon	**100% of URC**
Outpatient Surgical Facility Maximum Benefit per	**100% of URC**
Emergency Room Benefit	**100% of URC**
Anesthesia Benefit:	**100% of URC**
Physician's Visits	
In-Hospital Maximum Benefit:	**100% of URC**
Physician's Visits	
Office Visits (Out-of-Hospital) Maximum Benefit:	**100% of URC**
X-Ray Benefit	**100% of URC**
Laboratory Benefit	**100% of URC**
Nursing Benefit Amount:	**100% of URC**
Outpatient Physiotherapy Benefit	**100% of URC**
Ground Ambulance Benefit Amount:	**100% of URC**
Dental Treatment For Injury Only Benefit Amount:	**100% of URC**

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under {these Additional Accident Benefits} shown below {are paid in addition to} any {Accidental Death and Dismemberment} benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

The total of {all benefits payable under this Policy, including all Additional Accident Benefits} paid for all Injuries caused by the same Covered Accident shall not exceed the Principal Sum indicated in the *Schedule of Benefits* unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

Benefit payable per prescription	**100% of URC**

DURABLE MEDICAL EQUIPMENT BENEFIT **100% of URC**

Home Health Care Benefit

Deductible Amount per calendar year:	**$50**
Coinsurance per calendar year:	**75%**
Maximum visits per calendar year:	**40 4-hour visits**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Accident means a sudden, unforeseeable external event which:
1. Causes Injury to one or more Covered Persons; and
2. Occurs while coverage is in effect for the Covered Person.

Aircraft means a vehicle which:
1. Has a valid certificate of airworthiness; and
2. Is being flown by a pilot with a valid license appropriate to the aircraft.

Amateur means a sport or activity where the participants engage largely or entirely without compensation.

Amateur mean any participant in a combative sport, who is not receiving or competing for, and who has never received or completed for, any purse, money, proze, pecuniary gain, or other thing of value exceeding seventy-five dollars or the allowable amount established by the authorized amateur sanctioning entity overseeing the competition. **(**Used with Combative Sports only)

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Club means an organization of students formed for the purpose of engaging in competition in a particular sport or activity. Competition between student clubs from different colleges, not organized by and therefore not representing the institution or their faculties.

Listing of both partners as tenants on the lease of the shared residence;
Shared rental payments of residence (need not be shared 50/50);
Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc (need not be shared 50/50);
Shared household budget for purposes of receiving government benefits;
Status of one as representative payee for the other's government benefits;
Joint ownership of major items of personal property (e.g. appliances, furniture);
Joint ownership of a motor vehicle;
Joint responsibility for child care (e.g., school documents, guardianship);
Shared child-care expenses, e.g., babysitting, daycare, school bills (need not be shared 50/50);

a. Convalescent, custodial, educational or nursing care;
b. The aged, drug addicts or alcoholics;

2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. The services are rendered on an emergency basis; and
    b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Interscholastic means a sport or activity organized between schools or representatives of the schools.

Intramural means a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from “within the walls” of an institution or area.

Immediate Family Member means the Covered Person’s parent (includes step-parent), Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), or in-laws.

Leased Aircraft means an aircraft for which the Policyholder or any of its subsidiaries or affiliates has a written lease under whose terms, the aircraft:

1. Can be used at the Policyholder's or any of its subsidiaries’ or affiliates’ discretion;
2. Can be used by the Policyholder or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and
3. Cannot be altered or sold by the Policyholder or any of its subsidiaries or affiliates, without the consent of the leaser or owner.

Leased Aircraft does not include any Owned Aircraft.

Life Threatening Brain Injury means an acute brain injury that, in the opinion of the professional licensee’s treating physician, would result in the death of the professional licensee if left untreated. The Company is only liable for Life Threatening Brain Injuries that are sustained in a program operated under the control of a licensed promotor. The symptoms of the Life Threatening Brain Injury must first manifest themselves during, or within twenty-four (24) hours after the end of, the licensed professional’s participation in the covered program, and the injury must be diagnosed by a Physician during, or within forty-eight (48) hours after the end of, the licensed professional’s participation in the covered program.

Medically Necessary or Medical Necessity means a treatment, service or supply that is:

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

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate.

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

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Operated or Controlled Aircraft means an aircraft which:
1. Has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days, or more than 15 days in any one year;
2. Can be used at the Policyholder's discretion; and
3. Cannot be altered or sold by the Policyholder without the consent of the owner or leaser.

Operated or Controlled Aircraft does not include any Owned Aircraft.

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether Insured or uninsured.

School means the participating School or School District where the Covered Person is enrolled or employed. The School must be a duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate School.

Spouse means the lawful Spouse, if not legally separated or divorced, or Domestic Partneror Civil Partner, including same-sex partners legally married in other jurisdictions.

Supervised or Sponsored Activity means a Policyholder or School authorized function:
1. In which the Covered Person participates;
2. Which is organized by or under its auspices;

which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

Usual, Reasonable and Customary means:
1. With respect to fees or charges, fees for medical services or supplies which are;
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

Waiting Period means the length of time from the date of loss to the time when benefits can be received.

ELIGIBILITY FOR INSURANCE

Eligibility:
Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Application. This includes anyone who may become eligible while this Policy is in force.

EFFECTIVE DATES OF INSURANCE

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

Covered Person's Effective Date: A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:
1. The Effective Date of the Policy; or
2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form.

TERMINATION DATE OF INSURANCE

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

The Policy terminates automatically on the earlier of:
1. The Policy Termination Date shown in the Policy; or

2. The premium due date if premiums are not paid when due subject to any grace period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy

2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS. The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

Non-Duplication of Benefits Provision:
This provision applies if a Covered Person:
1. Is covered by any other blanket or group health care plan; and
2. Would, as a result, receive total medical expense or service benefits in excess of the expenses actually incurred.

In this case, the medical expense benefits we will pay under this Policy will be reduced by such excess. This provision does not apply if we would be primary under any coordination of benefit guidelines contained in the other health care plans.

Non-Duplication of Benefits (Pro Rata) Provision:
If there are benefits under other insurance which apply to the same benefits as this coverage, we will pay a pro rata share of the total amount of benefits which are available. In no case shall the total benefits exceed 100% of the charges.

Pro rata share means the proportion of the total benefit that the amount payable under one policy in the absence of such other insurance bears to the total applicable benefits under all such policies.

Coordination of Benefits Provision:
If a Covered Person is also covered under one or more other Plans, the benefits payable under this Policy will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of 1. and 2. below would exceed those Allowable Expenses:
1. The benefits that would be payable under this Policy without coordination; and
2. The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under this Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:
1. Those required benefits; and
2. All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Policy are determined if:
1. The Benefit Determination Rules would require this Policy to determine its benefits before that Plan; and
2. The other Plan has a provision that coordinates it

We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in our opinion, we or it needs for the purpose of the Coordination of Benefits. When payments that should have been made under this Policy based on the terms of this provision have been made under any other Plans, we have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under this Policy. We will be released from all liability under this Policy to the extent of these payments. When an overpayment has been made by us, at any time, we will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as we may determine.

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1. **Benefits not as a Dependent:**

The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.

2. **Dependent Benefits under Different Parent Plans:**

The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent's Plan.

When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
Notwithstanding the foregoing, in the case of a dependent child of divorced or separated parents, the following rules will apply:

a. If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:
b. The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;
c. The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

3. **Benefits for Person Longest Covered:**

When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Whenever used in this provision:

Plan means a form of coverage written on an expense incurred basis that provides benefits or services for, or because of, medical care or treatment. Plan includes:

1. Group insurance and group or group remittance subscriber contracts;
2. Uninsured arrangements of group coverage;
3. Group coverage through HMO's and other prepayment, group practice and individual practice plans;
4. Blanket insurance coverage except blanket school accident coverages or such coverages issued to substantially similar group as defined in paragraph six of subsection (d) of section 52.70 of this Part where the policyholder pays the premiums;
5. Service plan contracts, group or individual practice or other prepayment plans;
6. Coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or

7. Medicare plan or similar governmental plan offering benefits, limited to the hospital,medical and surgical benefits of the governmental program. However, Plan shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.
8. Group and individual mandatory automobile “nofault” and traditional mandatory automobile “fault” type contracts.

It does not include coverage under individual policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

Primary Plan means one whose benefits for healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either:

1. the plan either has no order of benefit determination rules, or it has rules which differ from those in the Certificate; or
2. all plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the plan determines its benefits first.

Secondary Plan means one that is not the primary plan. If a person is covered by more than one secondary plan, the order of Benefit Determination Rules of this contract decide the order in which the benefits are determined in relation to each other. The benefits of

ACCIDENT MEDICAL and DENTAL EXPENSE BENEFITS

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

Accident Medical Expense Benefits are only payable:
1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 90 days after the date of the Covered Accident.

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

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses**: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

2. **Intensive Care/Cardiac Care Room and Board** - charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)

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6. Out-Patient Surgery Benefits:

We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

a. necessary for treatment of the Covered Person; and
b. given in the outpatient department of a Hospital or an ambulatory surgical center.

7. **Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.
Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.

8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:

a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

10. **X-Ray Benefit -** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x -ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

11. **Laboratory Benefit-** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.

13. **Physiotherapy -** Charges for physiotherapy:

a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

12. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 12 months of the Accident..

will not pay the Hospital cages for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

AGGREGATE LIMIT

The Aggregate Limit Amount is shown in the Application. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
1. After the first 12 months insurance is in effect;
2. Coinciding with a change in the coverage provided or classes eligible; or
3. Coinciding with a change in the risks we have assumed.

We will give 31 days written notice of any change under 1. above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:
This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 120 daysafter the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid within 60 days of receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)

The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:
If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:

1. The Covered Person first agrees in writing to refund the lesser of:
    a. The amount we actually paid for such expenses; or
    b. The amount actually received from the third party for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:

1. Received in a covered Accident; and
2. Which are covered under:
    a. workers' compensation or similar statutory remedies available under law; or
    b. Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

FLORIDA WARNING:

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

THE UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way • Eatontown, NJ 07724

- A service, procedure or treatment that two documents from available medical and

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

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protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.