



# **AIG Domestic Accident & Health Division**

A Division of the AIG Companies<sup>SM</sup>

## **NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.**

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

### **INDEPENDENT CONTRACTORS OCCUPATIONAL ACCIDENT INSURANCE DESCRIPTION OF COVERAGE**

This Description of Coverage summarizes the accident insurance that National Union Fire Insurance Company of Pittsburgh, Pa. (herein called "the Company") provides to Insureds under the Policy issued to the Policyholder.

#### **SCHEDULE**

#### **1. GENERAL INFORMATION**

**Name of Insured:**

**Policyholder:** AIG Group Insurance Trust  
c/o BNYM (Delaware), as Trustee  
100 White Clay Center, Route 273  
P.O. Box 6995, Newark, DE 19711  
Attn: Corporate Trust Administration

**Policy Number:** OCC 0009123547

**Contractee:**

**Administrator:** U.S. Risk

**Description of**

**Coverage Number:**

**Effective Date:**

#### **2. ELIGIBILITY**

**Class:      Description of Eligible Classes:**

- 1      All active Artists' (Rap, Hip Hop and Heavy Metal), Set Designers (incl. sounds, lighting, & Spec. effects) Sound, Lighting & Special Effects Technicians (No Pyrotechnics), Stage Construction, Construction Carpentry, including pipeline (other than oil and gas), and Site/Project Managers under age 65, of the Contractee under a contract agreement for whom the required premium has been paid and a completed enrollment form has been signed. (To and from Coverage is included).
  
- 2      All active independent Event Promoters, Artists (excluding Rap, Hip Hop and Heavy Metal greater than 25%) Artists Managers, Executive Officers, Personal Assistants, Runners, Chauffeurs, Drivers and Their helpers (Private Only – Taxi Drivers are not eligible), Materials Delivery, Set Up & Take Down Materials Workers such as Tents, Porta-Potties, etc under age 65, contracted with the Contractee under a contract agreement for whom the required premium has been paid and a completed enrollment form has been signed. (To and from Coverage is included).
  
- 3      All active full-time Independent Catering, Food or Beverages, Waste Providers, Clean Up Crews, Crowd Control & Similar (excluding Bouncers) under age 65, contracted with the Contractee under a contract agreement for which the required premium has been paid and a completed enrollment form has been signed. (To and from Coverage is excluded).

- 4 All active full-time Independent Volunteers as Ushers, Ticket Takers, under age 65, contracted with the Contractee under a contractual agreement for whom the required premium has been paid and a completed enrollment form has been signed. (To and from Coverage is excluded).
- 5 Pyrotechnicians under age 65, contracted with the Contractee under a contract agreement for whom the required premium has been paid and a completed enrollment form has been signed. (To and from Coverage is included).

**Coverage is mandatory, unless a contractor has coverage elsewhere.**

**3. PREMIUM RATES**

<b>Premium per Event* per Person: (Mandatory Participation Required)</b>	
<b>Class 1 –</b>	.....\$25.00
<b>Class 2 –</b>	.....\$20.00
<b>Class 3 –</b>	.....\$15.00
<b>Class 4 –</b>	.....\$7.00
<b>Class 5 –</b>	.....\$45.00

**\*Event – Defined as first day of Event Set Up through last day of complete Take Down.**

**IMPORTANT NOTICE**

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

**PLEASE READ THIS DESCRIPTION OF COVERAGE CAREFULLY.**

**4. SCHEDULE OF BENEFITS**

**Occupational Accident Benefits**

Applicable to Classes 1,2, 3, 4, 5

Accidental Death Benefit:

Principal Sum ..... \$200,000 – Lump Sum  
Incurral Period ..... 365 days  
Deductible Amount ..... N/A

Accidental Dismemberment Benefit:

Principal Sum ..... \$200,000  
Incurral Period ..... 365 days  
Deductible Amount ..... N/A

Temporary Total Disability Benefit\*:

Commencement Period (Initial Disability) ..... 90 days  
Waiting Period ..... 7 days  
Participation Percentage ..... 70 %  
Maximum Weekly Benefit Amount ..... \$600.00  
Maximum Benefit Period ..... 104 weeks

\*Benefits are Non-Retroactive

Continuous Total Disability Benefit:

Participation Percentage ..... 70%  
Maximum Weekly Benefit Amount ..... \$600.00  
Maximum Benefit Period ..... To age 65  
Waiting Period ..... 104 weeks

Accident Medical Expense Benefit:

Commencement Period ..... 90 days  
Deductible Amount ..... \$0.00  
Maximum Benefit Period ..... 104 weeks  
Dental Maximum ..... \$250 per tooth, not to exceed \$2,500 per accident  
Maximum Benefit Amount ..... \$1,000,000.00

**5. LIMITS OF LIABILITY**

**Occupational Coverage**

Per-Insured Limit of Liability (Combined Single Limit) ..... \$1,000,000  
(all Covered Losses with respect to  
any one Occupational accident)

Aggregate Limit of Liability ..... \$2,000,000  
(all Covered Losses with respect to all  
Insureds in any one Occupational accident)

**SECTION I – GENERAL DEFINITIONS**

**Administrator** means the Administrator named in the Schedule.

**Combined Single Limit** means, with respect to any one Insured Person, the total amount of benefits that are payable under the Policy for or in connection with Injury sustained as the result of any one accident. When the Combined Single Limit has been reached, no further benefits shall be payable under the Policy, with respect to that Insured, for or in connection with Injury sustained as the result of that one accident.

**Contractee** means the person, firm or other entity with whom the Insured has contracted to provide Occupational services.

**Covered Loss(es)** means all coverages listed in Section IV of this Description of Coverage.

**Functional Capacity Examination (FCE)** means a test performed by a physical therapy professional to evaluate and estimate physical limitations.

**Immediate Family Member** means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild).

**Injury** means bodily Injury to an Insured Person caused by an Occupational accident while coverage is in force under the Policy, which results directly and independently of all other causes in a Covered Loss. All Injuries sustained by an Insured in any one accident shall be considered a single Injury.

**Insured** means a person who: (1) is a member of an eligible class as described in the Description of Eligible Persons section of the Master Application; (2) has enrolled for coverage; and (3) has paid the required premium.

**Occupational** means, with respect to an activity, accident, incident, circumstance or condition involving an Insured, that the activity, accident, incident, circumstance or condition occurs or arises out of or in the course of the Insured performing services within the course and scope of contractual obligations for the Contractee, while under dispatch. Occupational does not encompass any period of time during the course of everyday travel to and from work.

**Occupational Cumulative Trauma** means bodily Injury to an Insured caused by the combined effect of repetitive physical Occupational activities extending over a period of time, where:

- (1) such condition is diagnosed by a Physician;
- (2) the Insured's last day of last performance of the activities causing the Injury occurred during the Policy Period; and
- (3) such activities resulted directly and independently of all other causes in a Covered Loss.

**Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the Insured's Occupational activities, where:

- (1) such condition is diagnosed by a Physician, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
- (2) exposure to such hazards is not an accident but is caused or aggravated by the conditions under which the Insured performs Occupational services;
- (3) the Insured's last day of last exposure to the environmental or physical hazards causing such condition occurs during the Policy Period; and (4) such exposure results directly and independently of all other causes in a Covered Loss.

**Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not:

- (1) the Insured;
- (2) an Immediate Family Member;
- (3) a practitioner retained by the Contractee.

**Pre-Existing Condition** means a condition for which an Insured has sought or received medical advice or treatment preceding his or her effective date of coverage under the Policy.

**Schedule** means the Schedule shown in this Description of Coverage.

**Spouse** means the Insured's legal spouse.

## **SECTION II – EFFECTIVE AND TERMINATION DATES**

**Effective Date.** The Policy begins on the Policy Effective Date shown in the Master Application at 12:01 A.M. Standard Time at the address of the Contractee where the Policy is delivered.

**Termination Date.** The Policy may, at any time, be terminated by mutual written consent of the Company and the Contractee. Otherwise, the Policy will terminate at 12:01 A.M. Standard Time at the Contractee's address on the earliest of:

1. the Policy Termination Date shown in the Master Application, unless renewed;
2. the premium due date if premiums are not paid when due subject to the Grace Period;
3. the date specified in the written notice of the Company's intent to terminate the Policy, which will be at least 31 days after the date the Company sends such notice to the Contractee's last known recorded address; or
4. the date specified in the written notice of the Contractee's intent to terminate the Policy, which will be at least 31 days after the date the Contractee sends such notice to the Company.

If the Company terminates the Policy, any unearned premium will be returned on a pro-rata basis. If the Contractee requests termination, the Company will return any unearned premium paid on a short-rate basis. Termination will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

## **SECTION III – PREMIUM**

**Insured's Premium.** The Premium Rate for coverage under the Policy for each Insured is shown in the Schedule.

## **SECTION IV – BENEFITS**

**Principal Sum.** As applicable to each Insured, Principal Sum means the amount of insurance in force under the Policy on the date of the accident, as described in the Schedule.

**Deductible.** The applicable per accident Deductible Amounts shown in the Schedule per Covered Loss apply to each Insured sustaining a particular type of Covered Loss. For accidents where more than one Covered Loss applies, the applicable per accident Deductible Amount shown in the Schedule per Covered Loss shall be applied separately to each benefit payable under the policy.

1. **Accidental Death Benefit.** If Injury to the Insured results in death within the Incurral Period shown in the Schedule, the Company will pay the Principal Sum, subject to any applicable Deductible Amount for the Accidental Death Covered Loss shown in the Schedule. The Incurral Period starts on the date of the accident that caused such Injury.

2. **Accidental Dismemberment Benefit.**

If Injury to the Insured results in any one of the Losses specified below, within the Incurral Period shown in the Schedule (as measured from the date of the accident that caused such Injury), the Company will pay

the Percentage of the Principal Sum shown below for that Loss, subject to any applicable Deductible Amount for the Accidental Dismemberment Covered Loss shown in the Schedule.:

<u>For Loss of:</u>	<u>Percentage of Principal Sum:</u>
Both Hands or Both Feet .....	100%
Sight of Both Eyes .....	100%
One Hand and One Foot.....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye .....	100%
Speech and Hearing in Both Ears .....	100%
One Hand or One Foot .....	50%
Sight of One Eye.....	50%
Speech or Hearing in Both Ears .....	50%
Thumb and Index Finger of Same Hand .....	25%

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

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

### 3. Temporary Total Disability Benefit:

If Injury to the Insured Person results in Temporary Total Disability within the Commencement Period, and if the Insured Person is under age 65 on the day the Temporary Total Disability begins, the Company will pay the Temporary Total Disability Benefit specified below, subject to satisfaction of any applicable Waiting Period. The Commencement Period starts on the date of the accident that caused such Injury.

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

1. the Participation Percentage of the Insured Person's Average Weekly Earnings; or
2. the Maximum Weekly Benefit Amount.

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

1. the date the Insured Person is no longer Temporarily Totally Disabled;
2. the date the Insured Person dies;
3. the date the Insured Person attains age 65; or
4. the date the Maximum Benefit Period has been reached.

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

As used above in this Temporary Total Disability benefit:

**Average Weekly Earnings** means the Insured Person's average weekly compensation earned for performing Occupational services, less any amounts withheld by or otherwise returned to the Contractee, including but not limited to taxes, overhead and fuel charges. If the Insured Person is paid wholly or in part by commissions, Average Weekly Earnings also include commissions based on an average of the commissions paid to the Insured Person for performing Occupational services during the 104 weeks immediately preceding the onset of Temporary Total Disability. If the Insured Person was not performing such services for the Contractee during

the entire 104 week period, commissions are based on an average of the total number of weeks the Insured Person was performing such services for the Contractee.

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

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

**Maximum Benefit Period** means, with respect to Temporary Total Disability, the maximum period for which benefits shall be payable for a Temporary Total Disability Covered Loss during a Single Period of Total Disability.

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

**Temporary Total Disability, Temporarily Totally Disabled** means disability that: (1) prevents an Insured Person from performing the duties of his or her regular, primary occupation; and (2) requires that, and results in, the Insured Person receiving Continuous Care.

#### 4. Continuous Total Disability Benefit:

If Injury to the Insured, resulting in Temporary Total Disability, subsequently results in Continuous Total Disability, the Company will pay the Continuous Total Disability Benefit specified below, provided:

- A. benefits payable for a Temporary Total Disability Covered Loss ceased solely because the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, but the Insured remains disabled;
- B. the Insured is under age 65 on the day after the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached;
- C. the Insured has been granted a Social Security Disability Award for their disability; and
- D. their disability is reasonably expected to continue without interruption until the Insured dies.

The Continuous Total Disability Benefit with respect to each month of an Insured's Continuous Total Disability is equal to four and three-tenths (4.3) times the weekly benefit for Temporary Total Disability, less the Insured's primary Social Security Disability Award.

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

Benefits payable under the Temporary Total Disability Benefit before the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, will not be considered a Continuous Total Disability Benefit.

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

- A. the date the Insured is no longer Continuously Totally Disabled.
- B. the date the Insured dies.
- C. the date the Insured's Social Security Disability Award ceases.
- D. the date the Insured attains age 65.
- E. the date the Maximum Benefit Period shown in the Schedule for Continuous Total Disability has been reached.

As used above in this Continuous Total Disability benefit:

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

**Continuous Care** means at least monthly monitoring and/or evaluation of the disabling condition by a Physician. The Company must receive proof of continuing Continuous Total Disability on a quarterly basis.

**Continuous Total Disability, Continuously Totally Disabled** means disability that: (1) prevents an Insured from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience; and (2) requires that, and results in, the Insured receiving Continuous Care.

**Maximum Benefit Period** means, with respect to Continuous Total Disability, the maximum period for which benefits shall be payable for a Continuous Total Disability Covered Loss(es).

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

## 5. Accident Medical Expense Benefit.

If an Insured suffers an Injury that requires him or her to be treated by a Physician, within the Commencement Period, the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Benefit Amount and Maximum Benefit Period shown in the Schedule per Insured for all Injuries caused by a single accident, subject to any applicable Deductible Amount. The Commencement Period starts on the date of the accident that caused such Injury. The Deductible Amount for the Accident Medical Expense Benefit is the Deductible Amount shown in the Schedule, if any, which must be met from Usual and Customary Charges for Medically Necessary Covered Accident Medical Services incurred due to Injuries sustained by the Insured in that accident.

The Accident Medical Expense Benefit is in excess of benefits provided by other insurance. The amount otherwise payable under the Accident Medical Expense Benefit will be reduced by the total amount of medical care benefits provided by any other plan. The amount of benefits payable under other plans:

1. will be determined without reference to any coordination of benefits provisions, non-duplication of benefits provisions, or other similar provisions;
2. include any amount to which the Insured Person is entitled, regardless of whether claim is made for the benefits;
3. will include the reasonable value of any Covered Accident Medical Expense Services provided by other insurance.

Other plan means:

1. individual, group, blanket or franchise insurance;
2. group hospital, medical service, pre-payment, or health maintenance organization (HMO) plan;
3. labor-management trustee, union welfare, employer organization, or employee benefit organization plan;
- 4.
5. governmental programs (including provincial plans) or coverage required or provided by any statute;
6. automobile insurance medical payments benefit, or mandatory reimbursable expenses covered by no-fault; or
7. workers' compensation or similar law.

As used in this Accident Medical Expense Benefit provision:

**Ambulatory Medical Center** means a licensed public establishment with an organized staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing surgical procedures. Such establishment must provide continuous Physician and registered nursing (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital, a Physician's office, or a clinic.

**Covered Accident Medical Service(s)** means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician or a registered nurse (RN);
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy, Occupational therapy, and chiropractic care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any;
9. rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances;
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription; or
12. repair or replacement of Sound Natural Teeth damaged or lost as a result of Injury, up to the Dental Maximum, if any.

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

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

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

**Maximum Benefit Period** means, with respect to Accident Medical Expense, the maximum period for which benefits shall be payable for Covered Accident Medical Services for or in connection with a single Accident Medical Expense Covered Loss.

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

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

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

**Usual and Customary Charge(s)** means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

In addition to the Exclusions in the Exclusions section of this Description of Coverage, Usual and Customary Charges for Covered Accident Medical Services do not include, and benefits are not payable with respect to, any expense for or resulting from:

- A. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
- B. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
- C. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;
- D. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing;
- E. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense Benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense Benefit in lieu of such rental expense);
- F. Custodial Services; or
- G. Personal Comfort or Convenience Item(s).

**Right to Receive and Release Needed Information.** The Company has the right to decide which facts it needs to administer this coverage. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to pay the claim.

**Facility of Payment and Right of Recovery.** If a payment made under another Plan includes an amount that should have been paid under This Plan, the Company may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Company is more than it should have

paid under this benefit, it may recover the excess from the persons it has paid or for whom it has paid, insurance companies or other organizations.

**Plan** means any of the following group, group-type (such as, but not limited to, franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies; (2) subscriber contracts; (3) uninsured arrangements; (4) labor-management trustee, union welfare, employer organization, or employee benefit organization plan; (5) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans; (6) medical benefits coverage in automobile “no-fault” and traditional automobile “fault” type contracts; and (7) coverage under a governmental plan (including provincial plans) or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

**Allowable Expense** means the Usual and Customary Charge for a Medically Necessary item of expense for health care when the item of expense is covered at least in part by the Policy and is covered at least in part by one or more other Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid, if the reasonable cash value had been charged as the cost for the service and such expense would have been covered at least in part by the Policy.

## SECTION V – LIMITS OF LIABILITY

1. **Per-Insured Limit of Liability.** The Per-Insured Limit of Liability (Combined Single Limit) stated in the Schedule will be the total limit of the Company’s liability for all benefits payable under the Policy with respect to any one Insured arising out of Injury sustained by such individual as the result of any one accident.
2. **Aggregate Limit of Liability.** The Aggregate Limit of Liability stated in the Schedule will be the total limit of the Company’s liability for all benefits payable under the Policy with respect to all Insureds arising out of Injury sustained by one or more Insured(s) as the result of any one accident.

If the total of such benefits exceeds the Aggregate Limit of Liability, the Company shall not be liable to any Insured for a greater proportion of such Insured’s benefits than said Aggregate Limit of Liability bears to the total benefits afforded all such Insureds by all coverages listed in the Benefits section of this Description of Coverage.

## SECTION VI – EXCLUSIONS

No coverage is provided for any losses caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at suicide; intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;
2. sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning;
3. any Pre-Existing Condition;
4. Occupational Cumulative Trauma, unless (and to the extent as) specifically provided by the Policy;
5. Occupational Disease, unless (and to the extent as) specifically provided by the Policy;

6. hernia of any kind, unless (and to the extent as) specifically provided by the Policy;
7. hemorrhoids of any kind, unless (and to the extent as) specifically provided by the Policy;
8. performing, learning to perform or instructing others to perform as a master or crew member of any vessel while covered under the Jones Act or the United States Longshore and Harbor Workers' Act, or similar coverage;
9. declared or undeclared war, or any act of declared or undeclared war;
10. full-time active duty in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty;
11. any Injury for which the Insured Person is entitled to benefits pursuant to any workers' compensation law or other similar legislation;
12. any loss insured by employers' liability insurance;
13. accidents occurring while the Insured is working for or under contract with an entity other than the Contractee.
14. the Insured Person being under the influence of drugs or intoxicants, unless taken under the advice of his or her Physician; or
15. the Insured Person's commission of or attempt to commit a felony; or
16. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Person is:
  - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - c. riding as a passenger in an aircraft owned, leased or operated by the Contractee; or
17. any union "stop work" action.

## **SECTION VII – CLAIMS PROVISIONS**

### **Notice of Claim**

Written notice of claim must be given to the Company within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at American International Companies , Accident and Health Claims Division, P.O. Box 15701, Wilmington, DE 19850-5701, with information sufficient to identify the Insured Person, is deemed notice to the Company.

### **Proof of Loss**

Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

### **Claim Forms**

The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Contractee's name and the Policy number.

All claims are adjudicated in one claim office by experienced claims examiners.

## **Payment of Claims**

Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary. Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary.

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

The Company may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. Such request must be made no later than the time proof of loss is filed. Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

## **SECTION VIII – GENERAL PROVISIONS**

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

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

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

After an Insured has been insured under the Policy for two years during his lifetime, no statement made by the Insured, except a fraudulent one, will be used to contest a claim under the Policy. The Company may only contest coverage if the misstatement is made in a written instrument signed by the Insured and a copy is given to the Policyholder, the Insured or the beneficiary.

3. **Beneficiary Designation and Change.** The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured as shown on the Contractee's records kept on the Policy.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advance by the Company, the Contractee with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, the Contractee, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

Except with regard to the Survivor's Benefit described in the Benefits section of this Description of Coverage, if there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The

Insured's (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

4. **Physical Examination and Autopsy.** The Company has the right, at its own expense, to examine the person of any Insured whose Injury is the basis of a claim, when and as often as it may be reasonably required during the pendency of the claim. In the case of a disability claim, the Company also has the right to require the Insured, at the Company's expense, to submit to an Occupational Assessment and/or a Functional Capacity Examination. The Company may also require an autopsy where it is not prohibited by law.
5. **Legal Actions.** No legal action for a claim can be brought against the Company until sixty (60) days after receipt of proof of loss. No legal action for a claim can be brought against the Company more than three years after the time for giving proof of loss.
6. **Assignment.** An Insured may not assign any of his or her rights, privileges or benefits under the Policy.
7. **Subrogation.** To the total extent the Company pays for losses incurred, the Company may assume the rights and remedies of the Insured relating to such loss. The Insured agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.
8. **Right to Recover Overpayments.** In addition to any rights of recovery, reimbursement or subrogation provided to the Company herein, when payments have been made by the Company with respect to a Covered Loss in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the Policy, the Company shall have the right to recover such excess payment, from any one or more of the following: Any person to whom such payments were made (*i.e.* medical providers, etc.), the Insured, any insurance company, or any other organization(s) which received, or should have received, the payment.
9. **Conditional Claim Payment.** If an Insured suffers a Covered Loss(es) as the result of Injuries for which, in the opinion of the Company, a third party may be liable, the Company will pay the amount of benefits otherwise payable under the Policy. However, if the Insured receives payment from the third party, the Insured agrees to refund to the Company the lesser of: (1) the amount actually paid by the Company for such Covered Loss(es); or (2) an amount equal to the sum actually received from the third party for such Covered Loss(es). If the Insured does not receive payment from the third party for such Covered Loss(es), the Company reserves the right to subrogate under the Subrogation clause of the Policy.  
  
At the time such third party liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.
10. **Other Insurance.** If the Insured incurs losses for which benefits are payable under more than one like policy issued by the Company or one of its affiliates, the coverage under the Policy is in excess of such other insurance, and will not contribute to such a loss with such other insurance. This condition does not apply to: (1) the Accident Medical Expense benefit described in the Benefits section of this Description of Coverage; or (2) other insurance which the Insured has procured to apply in excess of the coverage under the Policy.
11. **Non-Duplication of Workers' Compensation Benefits.** No benefits shall be payable under the Policy for any loss for which the Insured claims coverage under any workers' compensation, employer's liability, occupational disease or similar law. The Company reserves the right to recover, from the Insured, any benefits paid under the Policy which are subsequently claimed under any workers' compensation, employer liability, occupational disease or similar law.

### **IMPORTANT**

If any conflict should arise between the contents of this Description of Coverage and the Master Policy OCC 0009123547, or if any point is not covered herein, the terms and conditions of the Master Policy will govern in all cases.



**AIG Domestic Accident & Health Division**

A Division of the AIG Companies<sup>SM</sup>

**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.**

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: AIG Group Insurance Trust c/o BNYM (Delaware), as Trustee

Policy Number: OCC 0009123547

Participating Organization:

**INDEPENDENT CONTRACTOR OCCUPATIONAL ACCIDENT INSURANCE**

This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder (herein called Insured(s)) against loss covered by this Policy, subject to its provisions, limitations and exclusions. The persons eligible to be Insureds are all persons described in the Description of Eligible Persons section of the Master Application.

This Policy is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Master Application, which is attached to and made part of this Policy and in the individual enrollment forms, if any.

This Policy begins on the Policy Effective Date shown in the Master Application and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent of the Company and the Policyholder at the premium rates in effect at the time of renewal.

**IMPORTANT NOTICE**

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

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

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Policy:

President

Secretary

**PLEASE READ THIS POLICY CAREFULLY**

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## SECTION I

## GENERAL DEFINITIONS

**Administrator** means the Administrator named in the Schedule.

**Combined Single Limit** means, with respect to any one Insured, the total amount of benefits that are payable under this Policy for or in connection with Injury sustained as the result of any one accident. When the Combined Single Limit has been reached, no further benefits shall be payable under this Policy, with respect to that Insured, for or in connection with Injury sustained as the result of that one accident.

**Contractee** means the person, firm or other entity with whom the Insured has contracted to provide Occupational services.

**Covered Loss(es)** means one or more of the losses or expenses described in Section IV of this Policy.

**Dependent Child(ren)** means the Insured's unmarried children, including natural children from the moment of birth, step children, or adopted children, from the moment of placement in the home of the Insured, under age 19(23 if attending an accredited institution of higher learning on a full-time basis) and primarily dependent on the Insured for support and maintenance. It also includes any unmarried Dependent Child(ren) of the Insured who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance.

The Company may require proof of the Dependent Child(ren)'s incapacity and dependency within 60 days before the Dependent Child(ren) reach the age limit specified above. The Company may request that satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency be submitted to the Company on an annual basis. If the requested proof is not furnished within 31 days of the request, such child(ren) shall no longer be considered Dependent Child(ren) as of the end of that 31 day period.

[Functional Capacity Examination \(FCE\) means a test performed by a physical therapy professional to evaluate and estimate physical limitations.](#)

**Home** means any personal residence, dwelling or space owned or rented by the Insured that is maintained for the purpose of habitation for any period of time, whether primary residence or other habitable residence, including motor or mobile homes. Home does not include any dwelling or space owned or rented by the Insured for business purposes only and not used as a residence at any time. Any space within a personal residence dwelling or other dwelling on the same premises of a Home used for business purposes is still considered part of a Home.

**Immediate Family Member** means a person who is related to the Insured in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild).

**Injury** means bodily Injury to an Insured caused by an Occupational accident while coverage is in force under this Policy, which results directly and independently of all other causes in a Covered Loss. All Injuries sustained by an Insured in any one accident shall be considered a single Injury.

**Insured** means a person who: (1) is a member of an eligible class as described in the Description of Eligible Persons section of the Master Application; (2) has enrolled for coverage; and (3) has paid the required premium.

**Occupational** means, with respect to an activity, accident, incident, circumstance or condition involving an Insured, that the activity, accident, incident, circumstance or condition occurs or arises out of or in the course of the Insured performing services within the course and scope of contractual obligations for the Contractee. Occupational encompasses any period of time during everyday travel between locations where services are to be performed. Occupational does *not* encompass any period of time during the course of everyday travel to the first location where services are performed and back from the last location where services are performed. Occupational also does *not* encompass any period of time during travel to or from locations of personal business (i.e. dry cleaners, bank, doctor's appointments, Home, etc.) during the course of travel to locations where services are to be performed.

**Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, Injury and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

**Occupational Cumulative Trauma** means bodily Injury to an Insured caused by the combined effect of repetitive physical Occupational activities extending over a period of time, where: (1) such condition is diagnosed by a Physician; (2) the Insured's last day of last performance of the activities causing the Injury occurred during the Policy Period; and (3) such activities resulted directly and independently of all other causes in a Covered Loss.

**Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the Insured's Occupational activities, where: (1) such condition is diagnosed by a Physician, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; (2) exposure to such hazards is not an accident but is caused or aggravated by the conditions under which the Insured performs Occupational services; (3) the Insured's last day of last exposure to the environmental or physical hazards causing such condition occurs during the Policy Period; and (4) such exposure results directly and independently of all other causes in a Covered Loss.

**Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) the Insured; or (2) an Immediate Family Member; or (3) a practitioner retained by the Contractee.

**Pre-Existing Condition** means a condition for which an Insured has sought or received medical advice or treatment during the twelve months immediately preceding his or her effective date of coverage under this Policy.

**Schedule** means the Schedule shown in the Master Application for this Policy which is attached to and made a part of this Policy.

**Spouse** means the Insured's legal spouse.

## SECTION II

## EFFECTIVE AND TERMINATION DATES

### Policy Effective and Termination Dates

**Policy Effective Date.** This Policy begins on the Policy Effective Date shown in the Master Application at 12:01 A.M. Standard Time at the address of the Policyholder where this Policy is delivered.

**Policy Termination Date.** This Policy may, at any time, be terminated by mutual written consent of the Company and the Policyholder. Otherwise, this Policy will terminate at 12:01 A.M. Standard Time at the Policyholder's address on the earliest of:

1. the Policy Termination Date shown in the Master Application, unless renewed;
2. the premium due date if premiums are not paid when due subject to the Grace Period;
3. the date specified in the written notice of the Company's intent to terminate this Policy, which will be at least 31 days after the date the Company sends such notice to the Policyholder's last known recorded address; or
4. the date specified in the written notice of the Policyholder's intent to terminate this Policy, which will be at least 31 days after the date the Policyholder sends such notice to the Company.

If the Company terminates this Policy, any unearned premium will be returned on a pro-rata basis. If the Policyholder requests termination, the Company will return any unearned premium paid on a short-rate basis. Termination will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

### Insured's Effective and Termination Dates

**Insured's Effective Date.** An Insured's coverage under this Policy begins on the latest of:

1. the Policy Effective Date;
2. the date the person becomes a member of an eligible class of persons as described in the Description of Eligible Persons section of the Master Application;
3. if individual enrollment is required, the date written enrollment is received by the Policyholder;
4. the date on which the first premium payment is paid when due.

**Insured's Termination Date.** An Insured's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date the Insured requests, in writing, that his or her coverage be terminated; or
4. the date the Insured ceases to be a member of any eligible class(es) of persons as described in the Description of Eligible Persons section of the Master Application.

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

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from an accident that occurred while the Insured's coverage was in force under this Policy.

### SECTION III

### PREMIUM

**Premiums.** Premiums are payable to the Company at the rates and in the manner described in the Premiums section of the Master Application. The Company may change the required premiums due on any Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 31 days advance written notice. The Company may change the required premiums as a condition of any renewal of this Policy. The Company may also change the required premiums at any time when any change affecting premiums is made in this Policy.

**Insured's Premium.** The Premium Rate for coverage under this Policy for each Insured is shown in the Schedule.

**Grace Period.** A Grace Period of 31 days will be provided for the payment of any premium due after the first premium. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the Grace Period.

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

No Grace Period will be provided if the Company receives notice to terminate this Policy prior to a premium due date.

**SECTION IV**

**BENEFITS**

**Principal Sum.** As applicable to each Insured, Principal Sum means the amount of insurance in force under this Policy on the date of the accident, as described in the Schedule.

**Deductible.** The applicable per accident Deductible Amounts shown in the Schedule per Covered Loss apply to each Insured sustaining a particular type of Covered Loss. For accidents where more than one Covered Loss applies, the applicable per accident Deductible Amount shown in the Schedule per Covered Loss shall be applied separately to each benefit payable under this Policy.

**Accidental Death Benefit**

If Injury to the Insured results in death within the Incurral Period shown in the Schedule, the Company will pay the Principal Sum, subject to any applicable Deductible Amount for the Accidental Death Covered Loss shown in the Schedule. The Incurral Period starts on the date of the accident that caused such Injury.

**Accidental Dismemberment Benefit**

If Injury to the Insured results in any one of the Losses specified below, within the Incurral Period shown in the Schedule (as measured from the date of the accident that caused such Injury), the Company will pay the Percentage of the Principal Sum shown below for that Loss, subject to any applicable Deductible Amount for the Accidental Dismemberment Covered Loss shown in the Schedule.

<u>For Loss of:</u>	<u>Percentage of the Principal Sum:</u>
Both Hands or Both Feet.....	100%
Sight of Both Eyes.....	100%
One Hand and One Foot.....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye .....	100%
Speech and Hearing in Both Ears .....	100%
One Hand or One Foot.....	50%
Sight of One Eye .....	50%
Speech or Hearing in Both Ears .....	50%
Thumb and Index Finger of Same Hand .....	25%

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Loss" of one thumb means complete severance through or above the metacarpophalangeal joint of the digit.

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

## Temporary Total Disability Benefit

If Injury to the Insured results in Temporary Total Disability within the Commencement Period shown in the Schedule, and if the Insured is under age 65 on the day the Temporary Total Disability begins, the Company will pay the Temporary Total Disability Benefit specified below, subject to satisfaction of any applicable Waiting Period shown in the Schedule. The Commencement Period starts on the date of the accident that caused such Injury.

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

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

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

1. the date the Insured is no longer Temporarily Totally Disabled;
2. the date the Insured dies;
3. the date the Insured attains age 65; or
4. the date the Maximum Benefit Period shown in the Schedule has been reached.

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

**Average Weekly Earnings** means the Insured's average weekly compensation earned for performing Occupational services less any amounts withheld by or otherwise returned to the Contractee, including but not limited to taxes, overhead and fuel charges. If the Insured is paid wholly or in part by commissions, Average Weekly Earnings also include commissions based on an average of the commissions paid to the Insured for performing Occupational services during the 104 weeks immediately preceding the onset of Temporary Total Disability. If the Insured was not performing such services for the Contractee during the entire 104 week period, commissions are based on an average of the total number of weeks the Insured was performing such services for the Contractee.

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

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

**Maximum Benefit Period** means, with respect to Temporary Total Disability, the maximum period for which benefits shall be payable for a Temporary Total Disability Covered Loss during a Single Period of Total Disability. The length of the Maximum Benefit Period for Temporary Total Disability is shown in the Schedule.

**Temporary Total Disability, Temporarily Totally Disabled** means disability that: (1) prevents an Insured from performing the duties of his or her regular, primary occupation; and (2) requires that, and results in, the Insured receiving Continuous Care.

## Continuous Total Disability Benefit

If Injury to the Insured, resulting in Temporary Total Disability, subsequently results in Continuous Total Disability, the Company will pay the Continuous Total Disability Benefit specified below, provided:

1. benefits payable for a Temporary Total Disability Covered Loss ceased solely because the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, but the Insured remains disabled;
2. the Insured is under age 65 on the day after the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached;
3. the Insured has been granted a Social Security Disability Award for their disability; and
4. their disability is reasonably expected to continue without interruption until the Insured dies.

The Continuous Total Disability Benefit with respect to each month of an Insured's Continuous Total Disability is equal to four and three-tenths (4.3) times the weekly benefit for Temporary Total Disability, less the Insured's primary Social Security Disability Award.

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

Benefits payable under the Temporary Total Disability Benefit before the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, will not be considered a Continuous Total Disability Benefit.

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

1. the date the Insured is no longer Continuously Totally Disabled.
2. the date the Insured dies.
3. the date the Insured's Social Security Disability Award ceases.
4. the date the Insured attains age 65.
5. the date the Maximum Benefit Period shown in the Schedule for Continuous Total Disability has been reached.

As used above in this Continuous Total Disability benefit:

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

**Continuous Care** means at least monthly monitoring and/or evaluation of the disabling condition by a Physician. The Company must receive proof of continuing Continuous Total Disability on a quarterly basis.

**Continuous Total Disability, Continuously Totally Disabled** means disability that: (1) prevents an Insured from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience; and (2) requires that, and results in, the Insured receiving Continuous Care.

**Maximum Benefit Period** means, with respect to Continuous Total Disability, the maximum period for which benefits shall be payable for a Continuous Total Disability Covered Loss(es). The length of the Maximum Benefit Period for Continuous Total Disability is shown in the Schedule.

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

## Accident Medical Expense Benefit

If an Insured suffers an Injury that requires him or her to be treated by a Physician, within the Commencement Period shown in the Schedule, the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Benefit Amount and Maximum Benefit Period shown in the Schedule per Insured for all Injuries caused by a single accident, subject to any applicable Deductible Amount. The Commencement Period starts on the date of the accident that caused such Injury. The Deductible Amount for the Accident Medical Expense Benefit is the Deductible Amount shown in the Schedule, if any, which must be met from Usual and Customary Charges for Medically Necessary Covered Accident Medical Services incurred due to Injuries sustained by the Insured in that accident.

As used in this Accident Medical Expense Benefit provision:

**Ambulatory Medical Center** means a licensed public establishment with an organized staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing surgical procedures. Such establishment must provide continuous Physician and registered nursing (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital, a Physician's office, or a clinic.

**Covered Accident Medical Service(s)** means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician or a registered nurse (RN);
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy, Occupational therapy, and chiropractic care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule;
9. rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances;
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription;
12. repair or replacement of Sound Natural Teeth damaged or lost as a result of Injury, up to the Dental Maximum, if any.

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

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

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

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

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

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

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

**Usual and Customary Charge(s)** means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

In addition to the Exclusions in Section VI of this Policy, Usual and Customary Charges for Covered Accident Medical Services do not include, and benefits are not payable with respect to, any expense for or resulting from:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;
4. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing;
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense Benefits for rental of Durable Medical Equipment are expected to exceed the

usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense Benefit in lieu of such rental expense);

6. Custodial Services; or
7. Personal Comfort or Convenience Items, such as but not limited to, Hospital telephone charges, television rental or guest meals.

## SECTION V

## LIMITS OF LIABILITY

**Per-Insured Limit of Liability.** The Per-Insured Limit of Liability (Combined Single Limit) stated in the Schedule will be the total limit of the Company's liability for all benefits payable under this Policy with respect to any one Insured arising out of Injury sustained by such individual as the result of any one accident.

**Aggregate Limit of Liability.** The Aggregate Limit of Liability stated in the Schedule will be the total limit of the Company's liability for all benefits payable under this Policy with respect to all Insureds arising out of Injury sustained by one or more Insured(s) as the result of any one accident.

If the total of such benefits exceeds the Aggregate Limit of Liability, the Company shall not be liable to any Insured for a greater proportion of such Insured's benefits than said Aggregate Limit of Liability bears to the total benefits afforded all such Insureds under this Policy.

## SECTION VI

## EXCLUSIONS

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

1. suicide or any attempt at suicide; intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;
2. sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning;
3. any Pre-Existing Condition;
4. Occupational Cumulative Trauma, unless (and to the extent as) specifically provided by this Policy;
5. Occupational Disease, unless (and to the extent as) specifically provided by this Policy;
6. hernia of any kind, unless (and to the extent as) specifically provided by this Policy;
7. hemorrhoids of any kind, unless (and to the extent as) specifically provided by this Policy;
8. performing, learning to perform or instructing others to perform as a master or crew member of any vessel while covered under the Jones Act or the United States Longshore and Harbor Workers' Act, or similar coverage;
9. declared or undeclared war, or any act of declared or undeclared war;
10. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
11. any Injury for which the Insured is entitled to benefits pursuant to any workers' compensation law or other similar legislation;
12. any loss insured by employers' liability or any other liability insurance;
13. accidents occurring while the Insured is working for or under contract with an entity other than the Contractee;
14. accidents occurring while the Insured is working while at their Home;
15. the Insured being under the influence of drugs or intoxicants, unless taken under the advice of his or her Physician;
16. the Insured's commission of or attempt to commit a felony;
17. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured is:
  - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - c. riding as a passenger in an aircraft owned, leased or operated by the Contractee; or
18. any union "stop work" action.

## SECTION VII

## CLAIMS PROVISION

**Notice of Claim.** Written notice of claim must be given to the Company within 20 days after an Insured's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at American International Companies , Accident and Health Claims Division, P. O. Box 15701, Wilmington, DE 19850-5701, with information sufficient to identify the Insured, is deemed notice to the Company.

**Claim Forms.** The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

**Proof of Loss.** Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

**Payment of Claims.** Upon receipt of due written proof of death, payment for loss of life of an Insured will be made to the Insured's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured suffering the loss. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

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

The Company may pay benefits directly to any Hospital or person rendering covered services, unless the Insured requests otherwise in writing. Such request must be made no later than the time proof of loss is filed. Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

**Time of Payment of Claims.** Benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

**Commutation of Losses.** It is agreed that, at the Company's option, at any time later than two years from the date of any accident resulting in a claim under this Policy, the Company may advise the Insured of its desire to be released from liability with respect to any such claim. In that event, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and the payment by the Company of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim.

**Sunset.** No claim made for losses sustained by Insureds will be considered valid and collectible in accordance with this Policy unless full details of such claim are presented to the Company within three years from the date of the accident which is the basis of such claim.

## SECTION VIII

## GENERAL PROVISION

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

No change in this Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

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

After an Insured has been insured under this Policy for two year(s) during his lifetime, no statement made by the Insured, except a fraudulent one, will be used to contest a claim under this Policy. The Company may only contest coverage if the misstatement is made in a written instrument signed by the Insured and a copy is given to the Policyholder, the Insured or the beneficiary.

**Beneficiary Designation and Change.** The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured as shown on the Contractee's records kept on this Policy.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advance by the Company, the Contractee with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, the Contractee, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

Except with regard to the Survivor's Benefit described in Section IV of this Policy, if applicable, in the event that there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured's: (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

**Physical Examination and Autopsy.** The Company has the right, at its own expense, to examine the person of any Insured whose Injury is the basis of a claim, when and as often as it may be reasonably required during the pendency of the claim. In the case of a disability claim, the Company also has the right to require the Insured, at the Company's expense, to submit to an Occupational Assessment and/or a Functional Capacity Examination. -The Company may also require an autopsy where it is not prohibited by law.

**Legal Actions.** No legal action for a claim can be brought against the Company until 60 days after receipt of proof of loss. No legal action for a claim can be brought against the Company more than three years after the time for giving proof of loss.

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

**Conformity With State Statutes.** Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered, is hereby amended to conform to the minimum requirements of such laws.

**Clerical Error.** Clerical error, whether by the Policyholder, the Contractee, the Administrator, or the Company in keeping records pertaining to this Policy, will not: (1) invalidate coverage otherwise validly in force, or (2) continue coverage otherwise validly terminated.

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

**Audit.** The Company will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder, the Contractee, and the Administrator that may have a bearing on this insurance.

**Assignment.** This Policy is non-assignable. An Insured may not assign any of his or her rights, privileges or benefits under the Policy.

**Subrogation.** To the total extent the Company pays for losses incurred, the Company may assume the rights and remedies of the Insured relating to such loss. The Insured agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

**Right to Recover Overpayments.** In addition to any rights of recovery, reimbursement or subrogation provided to the Company herein, when payments have been made by the Company with respect to a Covered Loss in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this Policy, the Company shall have the right to recover such excess payment, from any one or more of the following: Any person to whom such payments were made (*i.e.* medical providers, etc.), the Insured, any insurance company, or any other organization(s) which received, or should have received, the payment.

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

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

**Other Insurance.** If the Insured incurs losses for which benefits are payable under more than one like policy issued by the Company or one of its affiliates, the coverage under this Policy is in excess of such other insurance, and will not contribute to such a loss with such other insurance. This condition does not apply to: (1) the Accident Medical Expense benefit described in Section IV of this Policy; or (2) other insurance which the Insured has procured to apply in excess of the coverage under this Policy.

**Plan and Exposure Changes.** The Policyholder must notify the Company of any subsidiary or affiliated company that is to be covered under this Policy. Such notice must be sent within 30 days of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the Policyholder or a covered affiliate or subsidiary, and the Insureds from the newly acquired entity will not be considered as Insureds of the Policyholder or a covered affiliate or subsidiary for Policy purposes, until the date that notice is provided. The Company has the right to adjust premium based on the changing exposure.

**Non-Duplication of Workers' Compensation Benefits.** No benefits shall be payable under this Policy for any loss for which the Insured claims coverage under any workers' compensation, employers' liability,

occupational disease or similar law. The Company reserves the right to recover, from the Insured, any benefits paid under this Policy which are subsequently claimed under any workers' compensation, employers' liability, occupational disease or similar law.

**THIS ENDORSEMENT CHANGES THE POLICY.  
PLEASE READ IT CAREFULLY.**

**ENDORSEMENT #1**

This endorsement, effective June 20, 2008 12:01 A.M. forms a part of Policy No. OCC 0009123547 issued to AIG Group Insurance Trust c/o BNYM (Delaware), as Trustee by National Union Fire Insurance Company of Pittsburgh, PA

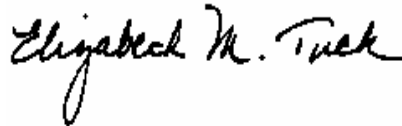
**COVERAGE TERRITORY ENDORSEMENT**

*This endorsement modifies insurance provided under the following:*

Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").



President



Secretary



## **AIG Domestic Accident & Health Division**

A Division of the AIG Companies<sup>SM</sup>

### **NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.**

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

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Policyholder: AIG Group Insurance Trust c/o BNYM (Delaware), as Trustee

Policy Number: OCC 0009123547

#### **PARTICIPATING ORGANIZATION ENDORSEMENT**

This Endorsement is attached to and made part of the Policy effective June 20, 2008. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

The following definition is added to the Definitions section of the Policy:

**Participating Organization** - means an organization: (1) which elects to offer coverage under this Policy by completing a Participation Organization Application that has been accepted by the Company; (2) which completes a participation agreement with the Policyholder; (3) which remits the required premium when due; and (4) while coverage through the Participating Organization is available under this Policy.

The following provisions are added to the Effective and Termination Dates section of the Policy:

**Participating Organization Effective Date.** A Participating Organization's coverage under this Policy begins on the later of: (1) the Participating Organization Effective Date shown in the Participating Organization Application at 12:01 A.M. Standard Time at the address of the Participating Organization shown in the Participating Organization Application; or (2) the Policy Effective Date shown in the Master Application.

**Participating Organization Termination Date.** The Participating Organization's coverage under this Policy may, at any time, be terminated by mutual written consent of the Company and the Participating Organization. Otherwise, the Participating Organization's coverage under this Policy will terminate at 12:01 A.M. Standard Time at the Participating Organization's address on:

1. the Participating Organization Termination Date shown in the Participating Organization Application, unless renewed;
2. the date required premiums are not paid when due, subject to the Grace Period;
3. the date specified in the written notice of the Company's intent to terminate the Participating Organization's coverage under this Policy, which will be at least 31 days after the date the Company sends such notice to the Participating Organization's last known recorded address;
4. the date specified in the written notice of the Participating Organization's intent to terminate coverage under this Policy, which will be at least 31 days after the date the Participating Organization sends such notice; or
5. the date the Policy terminates.

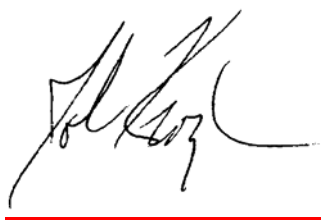
If the Company terminates this Policy, any unearned premium will be returned on a pro-rata basis. If the Participating Organization requests termination, the Company will return any unearned premium paid on a short-rate basis. Termination will not affect any claim for loss occurring prior to the effective date of termination.

The references in the Policy to “this Policy/coverage under this Policy”, “Master Application” and “Policyholder” may also, where applicable, mean “a Participating Organization’s coverage under this Policy”, “Participating Organization’s Application” and “Participating Organization”, respectively.

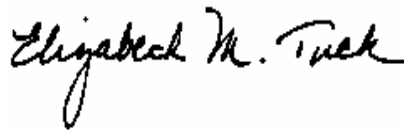
The following language applies to each Rider attached to the Policy:

Any Riders attached to this Policy apply only with respect to accidents that occur on or after the later of: (1) the effective date of each Rider; or (2) the effective date of the Participating Organization’s coverage under each Rider. Each Rider applies with respect to a Participating Organization’s coverage under this Policy only if the Participating Organization has elected the coverage described in each Rider as indicated in the Participating Organization Application.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:



President



Secretary

## HIPAA Privacy Notice

Administrative Offices

600 King Street, Wilmington, DE 19801

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

### Our Duties

By law, the Domestic Accident & Health Division of the American International Companies<sup>fl</sup> listed below is required to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

We are required to abide by the terms of this notice currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. In the event we revise the notice, we will provide you with a revised notice by mail.

### Your Individual Rights

With respect to protected health information, you have the following rights:

1. The right to request restrictions on certain uses and disclosures of protected health information including the uses and disclosures listed in this notice and permitted disclosures. However, we are not required to agree to a requested restriction;
2. The right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations;
3. The right to inspect and copy your protected health information in our records, except for:
  - psychotherapy notes;
  - information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
  - protected health information that is subject to a law prohibiting access to that information; or
  - if the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny your request to inspect and copy your protected health information if:

- a licensed health care professional has determined that the access requested is reasonably likely to endanger your life or physical safety or the life or physical safety of another person;
- the protected health information makes reference to another person and a health care professional has determined that the access requested is reasonably likely to cause substantial harm to such other person; or
- a licensed health care professional has determined that the access requested by your personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny access on one of the above three grounds, you have the right to have the denial reviewed in accordance with applicable law;

4. The right to amend your protected health information contained in our records. However, if the information was not created by us, is not part of your medical or billing records, is not available for inspection, or the information is accurate and complete, we are not required to amend the information;

5. The right to receive an accounting of disclosures of protected health information made by us in the six years prior to the date on which the accounting is requested, except for disclosures:
- to carry out payment and health care operations as provided below;
  - for notification purposes, as provided by law;
  - for national security or intelligence purposes, as provided by law;
  - to correctional institutions or law enforcement officials, as provided by law; or
  - that occurred prior to April 14, 2003; and
6. The right to obtain a paper copy of this notice upon request if you are viewing this notice electronically.

### **Uses and Disclosures of Protected Health Information**

Under Federal law, we are permitted to use and disclose protected health information for the purposes of treatment, payment, and health care operations.

**Treatment.** We do not provide treatment.

**Payment.** Payment refers to activities involving collection of premium and payment of claims. Examples of uses and disclosures under this section include (1) sharing protected health information with other insurers to determine coordination of benefits, the administration of claims, determining coverage, and providing benefits; and (2) sharing protected health information with third party administrators for the processing of claims.

**Operations.** Operations refers to the business functions necessary for us to operate, such as quality assurance activities, audits, and complaint responses. Examples of uses and disclosures under this section include (1) using protected health information to for the purpose of underwriting and calculating premium rates, (2) using protected health information to perform legal, actuarial, and auditing services, (3) disclosing protected health information when responding to complaints, and (4) use of protected health information for general data analysis and long term management and planning.

We may also use or disclose your protected health information for other purposes permitted or required by law, including the following:

to you, as the covered individual;

to a personal representative designated by you to receive protected health information or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual;

to the Secretary of Health and Human Services, or any employee thereof, as part of an investigation to determine our compliance with the HIPAA Privacy Rules;

to a business associate as part of a contracted agreement to perform services for the group health plan;

to a health oversight agency, such as the Insurance Commissioner's Office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses;

in response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding;

as required for law enforcement purposes;

as required to comply with Workers' Compensation or other similar programs established by law.

The examples of permitted uses and disclosures listed above are not provided as an all inclusive list of the ways in which protected health information may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Other uses and disclosures of your protected health information may be made only with your written authorization unless otherwise permitted or required by law. You may revoke such authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your protected health information in good faith with the authorization.

### **Complaints Regarding Your Privacy Rights**

If you believe your privacy rights have been violated, you may complain to the Secretary of Health and Human Services or you may file a complaint with us. Address your complaint to HIPAA Privacy Officer, 600 King Street, 8<sup>th</sup> Floor, Wilmington, DE 19801. You will not be retaliated against by us for filing a complaint.

### **Contact Us**

For further information regarding any matter covered by this notice, contact HIPAA Privacy Officer, Administrative Offices, 600 King Street, 8<sup>th</sup> Floor, Wilmington, DE 19801 or at 1-866-244-4786.

### **Effective Date**

This notice becomes effective on April 14, 2003.



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! National Union Fire Insurance Company of Pittsburgh, Pa. ! The Insurance Company of the State of Pennsylvania  
! American International South Insurance Company ! American Home Assurance Company ! Illinois National Insurance Company  
! AIG Life Insurance Company ! American International Life Assurance Company of New York  
Members of American International Group, Inc.

AIG Claim Services  
A&H Claims Department  
P. O. Box 15701  
Wilmington, DE 19850-5701  
800-551-0824/302-661-4176

**PROOF OF LOSS**

**NAME OF GROUP:**

**POLICY NUMBER:**

**CERT:**

**OCCUPATIONAL ACCIDENT MEDICAL CLAIM FORM**

**INSTRUCTIONS:**

- 1.) You must have SECTION A fully completed by a designated official of the Participating Organization.
  - 2.) SECTION B is to be completed, signed and dated by the Claimant.
  - 3.) If claimant is treated in the hospital, please attach an itemized hospital bill.
  - 4.) If claimant is treated by a doctor, SECTION C is to be completed, signed and dated by the Attending Physician or attach an itemized bill.
  - 5.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
  - 6.) Mail completed form to the address indicated above.
- The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

**SECTION A- PARTICIPATING ORGANIZATION STATEMENT**

NAME / ADDRESS OF PARTICIPATING ORGANIZATION

CLAIMANT'S FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	NAME OF SUPERVISOR
DATE OF INJURY:	WAS HE/SHE INJURED ON YOUR JOB? YES NO		
DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED			

DATE CLAIMANT WAS CONTRACTED:	EFFECTIVE DATE OF COVERAGE UNDER PLAN:	DATE COVERAGE TERMINATED (IF APPLICABLE)	
PARTICIPATING ORGANIZATION REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ( ) -	
SIGNATURE OF PARTICIPATING ORGANIZATION REPRESENTATIVE			DATE

**SECTION B- CLAIMANT'S STATEMENT**

CLAIMANT'S FULL NAME (PLEASE PRINT)			SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP	
DATE OF BIRTH	TELEPHONE ( )			
GIVE FULL DESCRIPTION OF INJURY OR DISEASE FROM WHICH YOU ARE NOW SUFFERING. IF AN INJURY, TELL WHEN IT HAPPENED (DATE AND TIME), PLACE WHERE ACCIDENT OCCURRED, WHAT YOU WERE DOING AND HOW IT HAPPENED.				
HAVE YOU EVER HAD THIS, OR A SIMILAR CONDITION, IN THE PAST? YES NO. IF YES, STATE THE NATURE OF THE CONDITION, DATES OF TREATMENT AND NAMES AND ADDRESSES OF TREATING DOCTORS, HOSPITALS AND CLINICS.				
WHEN DID YOU FIRST CONSULT A PHYSICIAN FOR THIS CONDITION?				
HOSPITALS (GIVE COMPLETE NAMES, ADDRESSES AND DATES OF CONFINEMENT.)				
GIVE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL ATTENDING PHYSICIANS.				
GIVE NAME, ADDRESS AND TELEPHONE NUMBER OF USUAL FAMILY PHYSICIAN.				
WHAT OTHER ACCIDENT, SICKNESS OR DISABILITY INSURANCE DO YOU CARRY AND WHAT OTHER ORGANIZATIONS OR COMPANIES HAVE PAID YOU BENEFITS FOR SICKNESS OR INJURY?				

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**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."

**For residents of New York:** 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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

**For claimants not residing in California, New York, or Pennsylvania:** 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.

SIGN YOUR FULL NAME

DATED:

**Section B**

**HEALTH INSURANCE CLAIM FORM**

**CLAIMANT INFORMATION**

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (ID)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS/CHAMPVA GROUP HEALTH PLAN <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID)	FECA/BLK LUNG <input type="checkbox"/> (SSN)	1a. INSURED'S I.D. NUMBER
---	---	---	---	---------------------------

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)	3. PATIENT'S DATE OF BIRTH MM / DD / YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
---	--	--	---

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)	7. INSURED'S ADDRESS (No., Street)
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CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY	STATE
ZIP CODE	TELEPHONE NO. ( )	Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE	TELEPHONE NO. ( )

9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> D. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER		3. PATIENT'S DATE OF BIRTH MM / DD / YY
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>
C. EMPLOYER'S NAME OR SCHOOL NAME		B. EMPLOYER'S NAME OR SCHOOL NAME
D. INSURANCE PLAN NAME OR PROGRAM NAME		C. INSURANCE PLAN NAME OR PROGRAM NAME
		D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to & complete item 9 A-D

**12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE.**  
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.**  
I authorize payment of medical benefits to undersigned physician or supplier for service described below.

Signature \_\_\_\_\_ Date \_\_\_\_\_

14. DATE OF CURRENT: MM / DD / YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY	16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / /
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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / /
---	---	--

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1 _____ 3 _____ 2 _____ 4 _____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
---	--

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHA \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
---	---------------------------	--	---------------------	-----------------------	-----------------------

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).	33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #  PIN# _____ GRP# _____
--	---	--

- PLACE OF SERVICE CODES
- |                              |                              |                                  |                               |
|------------------------------|------------------------------|----------------------------------|-------------------------------|
| 1-(H) - INPATIENT HOSPITAL   | 4-(H)-PATIENT'S HOME         | 7-(NH) NURSING HOME              | O-(OL)-OTHER LOCATIONS        |
| 2-(OH) - OUTPATIENT HOSPITAL | 5- -DAYCARE FACILITY (PSY)   | 8-(SNF)-SKILLED NURSING FACILITY | A-(IL)-INDEPENDENT LABORATORY |
| 3-(O) - DOCTOR'S OFFICE      | 6- -NIGHT CARE FACILITY(PSY) | 9- -AMBULANCE                    | B- -OTHER                     |

AIG Claim Services  
A&H Claims Department  
P. O. Box 15701  
Wilmington, DE 19850-5701  
800-551-0824/302-661-4176

**PROOF OF LOSS**

**NAME OF GROUP:**

**POLICY NUMBER:**

**CERT:**

**OCCUPATIONAL ACCIDENT DISABILITY CLAIM FORM**

**INSTRUCTIONS:**

- 1.) You must have SECTION A fully completed by a designated official of the Participating Organization.
- 2.) SECTION B is to be completed, signed and dated by the Attending Physician.
- 3.) SECTION C is to be completed, signed and dated by Claimant.
- 4.) Mail completed form to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

**SECTION A- PARTICIPATING ORGANIZATION STATEMENT FOR DISABILITY**

NAME / ADDRESS OF PARTICIPATING ORGANIZATION

CLAIMANT'S FULL NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH	NAME OF SUPERVISOR
DATE OF INJURY:	WAS HE/SHE INJURED ON YOUR JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED		
DATE CLAIMANT WAS CONTRACTED:	EFFECTIVE DATE OF COVERAGE UNDER PLAN:	DATE LAST WORKED:	TIME LAST WORKED:	
DATE LOSS TIME STARTED:	WEEKLY EARNINGS (PLEASE INCLUDE PAYROLL RECORDS FOR THE 3 MONTH PERIOD PRECEDING LOSS DATE)			
WILL CLAIMANT BE RECONTRACTED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE RETURNED TO WORK:		
PARTICIPATING ORGANIZATION REPRESENTATIVE (PLEASE PRINT OR TYPE)		TITLE	DAYTIME TELEPHONE NUMBER ( ) -	
SIGNATURE OF PARTICIPATING ORGANIZATION REPRESENTATIVE			DATE	

**SECTION B- ATTENDING PHYSICIAN'S STATEMENT FOR DISABILITY**

PATIENT NAME AND ADDRESS:

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?      DATE: \_\_\_\_\_

IF ACCIDENT DESCRIBE, HOW, WHEN AND WHERE ACCIDENT OCCURRED. \_\_\_\_\_

DIAGNOSIS AND CONCURRENT CONDITIONS (IF FRACTURE OR DISLOCATION, DESCRIBE NATURE AND LOCATION): \_\_\_\_\_

IS CONDITION DUE TO AN INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?       YES       NO

IF "YES," EXPLAIN. \_\_\_\_\_

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?      DATE: \_\_\_\_\_

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION?       YES       NO

IF "YES," STATE WHEN AND DESCRIBE: \_\_\_\_\_

NATURE AND DATE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE FULLY)      DATE: \_\_\_\_\_

PROVIDE DATES OF OTHER MEDICAL TREATMENT AND DESCRIBE: \_\_\_\_\_

WHAT OTHER SERVICES, IF ANY, DID YOU PROVIDE OR PRESCRIBE PATIENT? (PROVIDE DATES.) \_\_\_\_\_

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?       YES       NO

IF "NO," GIVE DATE YOUR SERVICES TERMINATED.      DATE: \_\_\_\_\_

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?      FROM: \_\_\_\_\_      TO: \_\_\_\_\_

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?      FROM: \_\_\_\_\_      TO: \_\_\_\_\_

IF PERMANENT PARTIAL DISABILITY, INDICATE PERCENTAGE OF IMPAIRMENT: \_\_\_\_\_

TO YOUR KNOWLEDGE, DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE?       YES       NO

IF "YES" IDENTIFY. \_\_\_\_\_

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE ( )
STREET ADDRESS		CITY OR TOWN	STATE OR PROVINCE      ZIP CODE

**SECTION C- CLAIMANT'S STATEMENT FOR DISABILITY**

CLAIMANT'S FULL NAME (PLEASE PRINT)			SOCIAL SECURITY NUMBER	
Street Address		City		State
Date Of Birth		Height And Weight	Marital Status	
Occupation		Duties	Monthly Earnings	Telephone (      )
				Weekly Earnings

(1) Give Full Description Of Injury Or Disease From Which You Are Now Suffering. If An Injury, Tell When It Happened (Date And Time), Place Where Accident Occurred, What You Were Doing And How It Happened.

(2A) Have You Ever Had This, Or A Similar Condition, In The Past?  Yes  No

(B) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics.

(3A) Give exact date when illness began, or injury occurred.	(A) Date:
(B) When did you first consult a physician for this condition?	(B) Date:
(C) When did you become totally disabled (unable to work)?	(C) Date:
(D) When were you able to again perform part of your occupational duties?	(D) Date:
(E) When were you able to again perform all of your occupational duties?	(E) Date:
(F) If still totally disabled, when do you expect your disability to end?	(F) Date:

(4) Hospitals (Give complete names, addresses and dates of confinement.)

(5A) Give names, addresses and telephone numbers of all attending physicians.

(B) Give name, address and telephone number of usual family physician.

(6) What other accident, sickness or disability insurance do you carry and what other organizations or companies have paid you benefits for sickness or injury?

(7) What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics.)

(8) Names, addresses and telephone numbers of employers and length of employment with each?

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**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.

**For residents of New York:** 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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**For claimants not residing in California, New York, or Pennsylvania:** 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.

SIGN YOUR FULL NAME \_\_\_\_\_

DATED: \_\_\_\_\_



f. Stamping fee of 0%:

\$0.00

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6. Authorized Surplus Lines Representative:

U.S. Risk, Inc.  
10210 N. Central Expressway #500  
Dallas, TX 75231

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**Authorized Representative or  
Countersignature (in states where required)**

**SURPLUS LINES NOTICE:**

**This insurance contract is issued pursuant to the Delaware Insurance Laws by an insurer neither licensed by nor under the jurisdiction of the Delaware Insurance Department.**

**IMPORTANT NOTICE**

**THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE. PLEASE READ THIS POLICY CAREFULLY.**



**AMERICAN INTERNATIONAL SPECIALTY  
LINES INSURANCE COMPANY**

**PLEASE READ CAREFULLY**  
**THIS POLICY COUNTAINS BOTH A SUNSET PROVISION FOR REPORTING CLAIMS AND A COMMUTATION PROVISION FOR SETTLING CLAIMS.**

**CONTINGENT LIABILITY POLICY**

In return for the payment of premium, We agree to provide the coverages of this Contingent Liability Policy to the Named Insured named in the Declarations. Coverage is effective for this Policy during the Policy Period listed in the Declarations. Various provisions in this policy restrict coverage. Coverage in the Policy is contingent on the occurrence of specified events. This Policy is delivered in, and subject to the applicable laws of the Contract Situs in which it is delivered or issued for delivery.

This is not a general liability insurance policy. Please read this Policy carefully to determine your rights, duties and obligations, and the insurance coverages that are provided herein.

As used in this Policy, the words “You” and “Your “ refer to the first Named Insured set forth in the Declarations Page and to any other person or organization qualifying as a Named Insured under this Policy. The words “We”, “Us”, “Our” and “Company” refer to the Company providing this coverage.

Any capitalized terms in this Policy, the Application and any riders, amendments, or other attached papers are to be given the meanings as provided in Section IV - Definitions, or as later defined herein.

**SECTION I - GENERAL**

**The Policy:** This Policy includes, at its effective date, the Policy, the Declarations and all endorsements and schedules listed. It is a contract of insurance between You and Us. The only agreements relating to this insurance are stated in this Policy. The terms of this Policy may not be changed or waived except by endorsement issued by Us to be part of this Policy.

**The Policy Period:** The Policy Period is shown in Item 2 of the Declarations. If this Policy is canceled, the Policy Period will end at 12:01 A.M. on the cancellation date.

**Who Is Insured:** In addition to the person(s) or organization(s) named in Item 1 of the Declarations, each of the following is also a Named Insured.

1. If the Named Insured in Item 1 of the Declarations is an individual, then his spouse, but only with respect to the conduct of a business of which the Named Insured is the sole owner.
2. If the Named Insured in Item 1 of the Declarations is a partnership or joint venture, then the partners and their spouses or members of the joint venture but only with respect to the conduct of the partnership’s or joint venture’s business.
3. If the Named Insured in Item 1 of the Declarations is a corporation, then the directors, officers and stockholders of the corporation, but only with respect to the conduct of the corporation’s business.

## SECTION II - INSURING AGREEMENTS

**Contract Liability:** We will reimburse You for the benefit You are required to pay under the workers' compensation laws of any state which is not covered by any other insurance because of an Occurrence resulting in Bodily Injury to a Covered Person; provided that:

1. it is determined by a court of law or the appropriate state regulatory authority that You are required to pay those benefits within 36 months after the date of the Occurrence, and
2. the Occurrence must take place during the Policy Period shown in Item 2 of the Declarations.

We will reimburse you for the benefits You are required to pay under the Occupational Disease laws of any State which is not covered by any other insurance because of an Occurrence resulting in Occupational Disease to a Covered Person; provided that:

1. it is determined by a court of law or the appropriate state regulatory authority that You are required to pay those benefits within 36 months after the date of the Occurrence, and
2. the Covered Person's last day of last known exposure to the conditions causing or aggravating such Occupational Disease must occur during the Policy Period shown in Item 2 of the Declarations.

We will reimburse You for the benefits required of You by the Workers' Compensation Law or Occupational Disease Laws of any state which is not covered by any other insurance. We are not permitted to pay the benefits directly to Covered Persons.

If We make any payments in excess of the benefits regularly provided by the Workers Compensation Law or Occupational Disease Law of any state on Your behalf, You will reimburse Us promptly.

## SECTION III - LIMIT OF LIABILITY

**Contract Liability:** The Limits of Liability shown on Item 4 of the Declarations is the most We will pay for all benefits payable for Bodily Injury or Occupational Disease under Contract Liability.

The Limits of Liability shown in Item 3 of the Declarations apply as follows:

1. The amount shown for each Covered Person is the most We will pay for all claims involving Bodily Injury or Occupational Disease covered by Contract Liability of this insurance to any one Covered Person in any one Occurrence.
2. Subject to 1 above, the amount shown for each Occurrence is the most We will pay for all claims involving Bodily Injury or Occupational Disease covered by Contract Liability of this insurance to one or more Covered Persons as the result of any one Occurrence.
3. Subject to 1 above, the amount shown as the policy limit is the most We will pay for all claims involving Bodily Injury or Occupational Disease covered by Contract Liability as the result of all Occurrences during the policy period shown in Item 2 of the Declarations.

The Limits of Liability shown for Each Covered Person, Each Occurrence, and Policy Limits apply only once regardless of the number of Named Insureds.

## SECTION IV - DEFINITIONS

**Accident** means an event which:

1. was unforeseen, unplanned and unexpected;

CL002-00

2. occurred at a specifically identifiable time and place;
3. occurred by chance or from unknown causes;
4. resulted in physical injury to a Covered Person;
5. arose out of a Covered Person's duties under a Covered Contract; and
6. occurred during the Policy Period.

**Bodily Injury** means bodily injury to an Independent Contractor caused by an Occupational Accident.

**Covered Contract** means a long-term lease or an agreement as defined by applicable state statute, regulation or otherwise. To be a Covered Contract such lease or agreement must satisfy all of the following requirements:

1. The contract must be signed by both the Named Insured and the Independent Contractor.
2. The contract must specify that the Independent Contractor's relationship with the Named Insured is that of an independent contractor who is at risk for profit or loss of his or her own individual business, and not that of an employee.
3. The Independent Contractor must be responsible for:
  - a. equipment maintenance; and
  - b. equipment operating costs, including but not limited to fuel, repairs, physical damage insurance, and personal expenses associated with the operation of the equipment;
4. The Independent Contractor must be responsible for hiring and supervising necessary personnel, who are independent contractors or employees of the Independent Contractor.
5. The Independent Contractor must be compensated on a basis other than one based solely on time expended in performing work.
6. The Independent Contractor must be responsible for determining the time, means and method of performing the work under such contract.
7. The Independent Contractor must be an independent contractor, and cannot be an employee of the Named Insured.
8. Compensation paid to the Independent Contractor must be reported via Internal Revenue Service Form 1099.

**Covered Person** means Independent Contractors; provided:

1. they have a written Covered Contract with You;
2. they are covered under an occupational accident policy approved by Us.
3. their name is on file with Us or Our administrator; and
4. they are not (prior to a claim under this Policy) a statutory employee of Yours or another Covered Person.

**Immediate Family Member** means a person who is related to the Independent Contractor in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes, legally adopted or placed for adoption, or stepchild).

**Independent Contractor** means a person who:

1. is an independent contractor as described by law;
2. Is not an employee of the Named Insured;
3. has entered into a Covered Contract with the Named Insured for his or her services, provided that such Covered Contract must be in effect when an Occurrence occurs;
4. is covered by an approved plan of Accident insurance which, in the event of a covered Accident, is designed to pay benefits to the Independent Contractor; and
5. does not own or control the Named Insured

**Named Insured** means the entity shown as the Named Insured in the Declarations to this Policy, and any covered wholly owned subsidiaries or divisions of the Named Insured.

**Occupational** means, with respect to an activity, accident, incident, circumstance or condition involving an Independent Contractor, that it occurs or arises out of or in the course of the Independent Contractor performing services pursuant to the Covered Contract that he or she has entered into with the Named Insured. Occupational does not encompass any period of time during the course of everyday travel to and from work.

**Occupational Disease** means a disease arising out of a Covered Person's Occupational duties which causes damage or harm to the physical structure of the body. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of a Covered Person's duties under a Covered Contract or a disease resulting directly from an Accident.

**Occupational Disease Law(s)** means the Occupational Disease laws of each state. It includes any amendments to that law which are in effect during the Policy Period. It does not include non-occupational disability benefits.

**Occurrence** means an Accident or series of Accidents arising out of one event or incident.

**Physician** means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: (1) the Independent Contractor; (2) an Immediate Family Member; or (3) a practitioner retained by the Named Insured.

**Workers Compensation Law(s)** means the workers' compensation law of each state. It includes any amendments to that law which are in effect during the policy period. It does not include non-occupational disability benefits.

## SECTION V - EXCLUSIONS

This Policy shall not apply to, and no coverage shall be provided under this Policy for or with respect to claims:

1. for liability assumed under any contract or agreement, including representations, warranties or indemnities of any kind, except a Covered Contract;
2. for fines, assessments, punitive damages or penalties whether arising under federal or state statute;
3. for an intentionally self-inflicted Bodily Injury or Occupational Disease to a Covered Person while either sane or insane or Bodily Injury or Occupational Disease intentionally caused or intentionally aggravated by You;
4. for Bodily Injury or Occupational Disease to a Covered Person while employed in violation of law with Your actual knowledge or the actual knowledge of any of Your executive officers;
5. for Bodily Injury or Occupational Disease occurring outside the United States of America, its territories or possessions and Canada, but this exclusion does not apply to a citizen or resident of the United States of America or Canada who is temporarily outside the United States of America, its territories or possessions or Canada at your direction and while in the course and scope of duties under a Covered Contract with You.
6. for benefits under any unemployment compensation law, disabilities benefits law or other similar law;
7. arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, violation of civil rights, discrimination against or termination of any

employee, or any personnel practices, policies, acts or omissions, whether under common law, federal law or state statute.

8. for Bodily Injury or Occupational Disease of any person arising out of or in the course of their employment that is subject to the Longshore and Harbor Workers Compensation Act (33 USC Sections 901-950), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356), The Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901-942), the Federal Employers Liability Act (45 USC Sections 51-60), and any other federal law, or any amendments to those laws.
9. relative to any person legally acknowledged by the Named Insured to be an employee thereof;
10. relative to employees of the Independent Contractor;
11. which did not arise out of the performance of Occupational services by the Covered Person;
12. arising out of the promulgation of any statute, regulation, or rule, or the amendment of any existing statute, regulation, or rule, the effect of which is to make an Independent Contractor an employee of the Named Insured for purposes of the workers' compensation law of the state of domicile of the Named Insured, of the state of jurisdiction of the Covered Contract, or of the state within which the Independent Contractor has sustained Bodily Injury or Occupational Disease;
13. for Bodily Injury or Occupational Disease brought by any similarly situated Independent Contractor which occurs subsequent to the issuance of any order by a workers' compensation board, governmental agency, or court of competent jurisdiction which has the precedential effect of making all similarly situated Independent Contractor employees of the Named Insured either: (1) in the state of domicile of the Named Insured; (2) in the state of jurisdiction of the Covered Contract; or (3) in the state within which the Independent Contractor sustained Bodily Injury or Occupational Disease;
14. where the Independent Contractor making such claim was not also a Named Insured under an approved plan of accident insurance on the date of the accident causing the Bodily Injury;
15. arising out of all statutory causes of action (except those brought under a Wrongful Death statute for damages that are otherwise defined as a Claim under this Policy), including, but not limited to: Title VII or Civil Rights Act of 1964; Civil Rights Act of 1991; Civil Rights Act of 1966; Age Discrimination in Employment Act; Americans with Disabilities Act; Employee Retirement Income Security Act; Fair Labor Standards Act; Bankruptcy Code; State Human Rights Act; Railway Labor Act; and National Labor Relations Act; as amended;
16. arising out of Independent Contractor's commission of or attempt to commit a felony;
17. arising out of the Independent Contractor's being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.
18. for damages arising out of or in any way involving:
  - a. your actual or alleged violation of any workers' compensation law or the Employee Retirement Income Security Act of 1974, as amended, or any similar federal, state, or local law; or
  - b. the administration of the Occupational Accident Plan including but not limited to claim handling or the failure to pay or the delay in payment of any Plan benefits.
19. resulting from a Covered Person's participation in:

- a. a riot or act of civil disturbance;
- b. a war, declared or undeclared;
- c. any act of war; or
- d. the service of the armed forces of any country or any civilian non-combatant unit serving with such forces.

## **PREMIUM**

**Premiums:** You are responsible for the payment of all premiums required to be paid under this Policy and You will be the payee for any return premiums We pay.

A grace period of 31 days is allowed for payment of each monthly premium due after the first month unless this Policy is canceled on or before the first day of the month. The Policy will continue in force during this grace period. If premium is not paid by the end of the grace period, coverage terminates at the end of the month for which premium was paid.

The premiums determined above are 100% earned. Should this policy be canceled by either You or Us for any reason, all premiums are fully earned and no return premium will be due.

The premium is determined by applying the monthly rate per person to the number of Covered Persons.

We have the right to change the rates at which future premiums will be calculated on the first day of any month. We will notify You of any change at least 30 days before the premium due date on which the new rates are to be effective.

**Premium Audit:** We will compute all premiums for this Policy in accordance with Our rules and rates.

Premium shown in this Policy as advance premium is a deposit premium only. At the close of each audit period, We will compute the earned premium for that period. Audit premiums are due and payable on notice to You. If the sum of the advance and audit premiums paid for the term of this Policy is greater than the earned premium, We will return the excess to You.

You must keep records of all information We require for premium computation and must send Us copies of such information at such times as We may request.

## **CLAIMS**

**Our Duty to Defend:** We have the right to defend You against any claim, proceeding or suit against You for Bodily Injury or Occupational Disease covered by this insurance. We have the right to investigate and settle any claim, proceeding or suit at Our discretion. We have no duty to defend or continue defending after We have paid Our applicable Limit of Liability shown in Item 4 of the Declarations.

### **Your Duties in the Event of a Claim or Suit:**

You shall cooperate fully with Us and assist Us in the investigation, settlement or defense of any claim, proceeding or suit and shall, upon Our request, supply;

1. the names and addresses of the injured Covered Person(s) and any witness(s);
2. all notices, demands and legal papers related to a Bodily Injury or Occupational Disease covered under this insurance; and
3. such other information as We may require.

You must notify Us as soon as practicable in the event of a claim or a situation which may result in a claim. To the extent possible, notices should include:

1. How, when and where the underlying Occurrence which gave rise to the claim took place;
2. The names and addresses of any injured persons and witnesses to the Occurrence;
3. A copy of the Covered Contract; and
4. The nature and location of any Bodily Injury arising out of the Occurrence or offense.

**Claim Reporting:** You must:

1. Immediately send Us copies of any demands, notices, summonses, or legal papers received in connection with the claim;
2. Authorize Us to obtain records or other information;
3. Authorize Us to serve you as your representative at any and all hearings or proceedings related to the claim; and
4. Assist Us, upon request, in the enforcement of any right against any person or organization which may be liable to the Named Insured because of Bodily Injury to which this insurance may apply.

Your failure to notify Us of a claim within the time frame outlined above will result in no coverage for that particular claim.

You may not, except at Your own cost and expense, voluntarily make any payment, assume any obligation, or incur any expense without Our prior written consent.

Notices are to be sent to American International Companies, Accident and Health Claims Division, P. O. Box 15701, Wilmington, DE 19850-5701.

**Subrogation - Recovery From Others:** We have Your rights to recover any payments We may make under this insurance from anyone liable for Bodily Injury or Occupational Disease covered by this insurance. You will do everything necessary to protect those rights for Us and help Us enforce them. You agree to do nothing that would interfere with those rights after any Bodily Injury or Occupation Disease.

**Commutation:** We have the right to commute all claims at any point after sixty months from the end of the Policy Period. All claims which are not finally settled will be eligible for commutation. An independent actuary or appraiser shall be appointed by mutual agreement between You and Us. The independent actuary or appraiser shall investigate, determine and capitalize the present value of such unsettled claims. We will share the expenses of the independent actuary or appraiser with You equally.

If We cannot mutually agree to an independent actuary or appraiser, each of Us will appoint their own independent actuary or appraiser who will, in turn, appoint a third independent actuary or appraiser who will establish the present value of each claim(s). Each of Us will pay the expenses of their own independent actuary or appraiser and share the expenses of the third independent actuary or appraiser equally.

We will pay You the present value determined by the independent actuary or appraiser within 30 days from receipt of the independent actuary's or appraiser's report. Upon receipt of Our payment, You agree to release Us from any further liability under this policy for such claim(s).

## **GENERAL CONDITIONS**

**Other Insurance:** If any other insurance, indemnity or reimbursement agreement exists protecting You for Bodily Injury or Occupational Disease to which this insurance applies, this insurance shall be excess of such other insurance, indemnity or reimbursement agreement. But this does not apply to any excess insurance, indemnity or reimbursement agreement specifically purchased by You to apply in excess of Our Limit of Liability.

**Representations.:** By accepting this Policy, You represent and warrant that:

1. All statements in the Declarations and the Application are accurate and complete;
2. Those statements are based upon representations You have made to Us;
3. We have issued this Policy in reliance upon Your representations; and
4. It is warranted that You have not disclosed nor will You disclose the existence of this Policy to any covered Independent Contractor.

**Cancellation:** You may cancel this Policy by mailing or delivering to Us at least 10 days written notice of cancellation. We may cancel this Policy by mailing or delivering to You written notice of cancellation at least:

1. 10 days before the effective date of cancellation if We cancel for nonpayment of premium; or
2. 30 days before the effective date of cancellation if We cancel for any other reason.

We may also cancel this Policy immediately if, during the adjudication of any claim, it is determined that all Independent Contractor covered under this Policy are found or deemed to be employees of the Named Insured and thus eligible for workers' compensation benefits. We will mail or deliver Our notice of cancellation to the last mailing address known to Us. Notice of cancellation will state the effective date of cancellation. The coverage will end on that date. If notice is mailed, proof of mailing will be sufficient proof of notice.

**Audit:** You agree to keep records of information needed to compute premium. You agree to let Us or Our representative examine and audit all Your payroll, business records, and documents including ledgers, journals, registers, vouchers, contracts, tax reports, disbursement records and programs for storage or retrieving data. We have the right to conduct audits during regular business hours while this Policy is in force and within three (3) years after the final settlement of all claims under this Policy.

**Bankruptcy or Insolvency:** Your bankruptcy or insolvency will not relieve Us from liability under this Policy. However, Our liability will be the same as it would have been had Your bankruptcy not or insolvency not occurred and coverage will be subject to all the terms and conditions of this Policy including your duty to cooperate.

**Captions:** The headings or captions used in this Policy are for the purposes of reference only and do not otherwise affect the meaning of this Policy.

**Conformity:** If any terms of this Policy are in conflict with any law applicable to this Policy, the Policy is hereby amended to conform to such law.

**Inspection:** We have the right, but not the duty, to inspect Your operations and work places. Such inspections are not safety inspections. They relate only to the insurability of the work places and the premium to be charged. We may give reports to You on the conditions found upon inspection. We do not undertake to provide for the health or safety of Your employees, independent contractors or the public. We do not warrant that Your work places are safe or healthful or that they comply with any law, regulation, code or standard.

**Transfer of Your Rights and Duties Under This Policy:** Your rights and duties under this Policy may not be transferred or assigned without Our prior written consent.

If the Named Insured is an individual and dies during the term of this Policy, such Named Insured's rights and duties will be transferred to his or her legal representative, but only while acting within the scope of duties as legal representative of the Named Insured. Until such legal representative is appointed, anyone having proper temporary custody of such Named Insured's property will have such person's rights and duties, but only with respect to that property.

**Service of Suit.** In the event of failure of the Company to pay any amount claimed to be due hereunder, the Company, at the request of the Named Insured, will submit to the jurisdiction of a court of competent

jurisdiction within the United States. Nothing in this condition constitutes or should be understood to constitute a waiver of the Company's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. It is further agreed that service of process in such suit may be made upon General Counsel, Legal Department, American International Specialty Lines Insurance Company, 70 Pine Street, New York, NY 10270, or his representative, and that in any suit instituted against the Company upon this contract, the Company will abide by the final decision of such court or of any appellate court in the event of any appeal.

Further, pursuant to any statute of any state, territory, or district of the United States which makes provision therefor, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance, other officer specified for that purpose in the statute, or his or her successor or successors in office as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the Insured or any beneficiary hereunder arising out of this contract of insurance, and hereby designates the above named General Counsel as the person to whom the said officer is authorized to mail such process or a true copy thereof.

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In Witness Whereof, the Company has caused this Policy to be signed by its President and Secretary and signed on the Declarations Page by a duly authorized representative of the company or countersigned in states where applicable.

  
Elizabeth M. Tuck

Secretary



John O'Brien

President

**POLICYHOLDER NOTICE**

Thank you for purchasing insurance from a member company of American International Group, Inc. (AIG). The AIG member companies generally pay compensation to brokers and independent agents, and may have paid compensation in connection with your policy. You can review and obtain information about the nature and range of compensation paid by AIG member companies to brokers and independent agents in the United States by visiting our website at [www.aigproducercompensation.com](http://www.aigproducercompensation.com) or by calling AIG at 1-800-706-3102.

# **IMPORTANT NOTICE TO OUR CUSTOMERS REGARDING THE OFFICE OF FOREIGN ASSETS CONTROL**

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Your rights as a policyholder and payments to you, any insured, additional insured, loss payee, mortgagee, or claimant, for loss under this policy may be affected by the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL ("OFAC").

## **WHAT IS OFAC?**

OFAC is an office of the Department of the Treasury and acts under presidential wartime and national emergency powers, as well as authority granted by specific legislation, to impose controls on transactions and freeze foreign assets under U.S. jurisdiction. OFAC administers and enforces economic embargoes and trade sanctions primarily against:

- Targeted foreign countries and their agents
- Terrorism sponsoring agencies and organizations
- International narcotics traffickers

## **PROHIBITED ACTIVITY**

- OFAC enforces certain embargoes and sanctions against certain designated countries. No U.S. business or person may enter into certain transactions in or connected to such designated "sanctioned" countries.
- OFAC maintains a directory known as the "Specially Designated Nationals and Blocked Persons" ("SDNBP") list. No U.S. business or person may transact business with any person or entity named on the SDNBP list.

Additional and more in-depth information on OFAC is available at the following website:  
<http://www.ustreas.gov/offices/eotffc/ofac>.

## **OBLIGATIONS PLACED ON US BY OFAC**

If we determine that you or any insured, additional insured, loss payee, mortgagee, or claimant are on the SDNBP list or are connected to a sanctioned country as described in the regulations enforced by OFAC, we must block or "freeze" property and payment of any funds transfers or transactions and report all blocks to OFAC within ten (10) days.

## **POTENTIAL ACTIONS BY US**

1. We may immediately cancel your coverage effective on the day that we determine that we have transacted business with an individual or entity associated with your policy on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.
2. If we cancel your coverage, you will not receive a return premium unless approved by OFAC. All funds will be placed in an interest bearing blocked account established on the books of a U.S. financial institution.
3. We will not pay a claim, accept premium or exchange monies or assets of any kind to or with individuals, entities or companies (including a bank) on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC. And, we will not defend or provide any other benefits under your policy to individuals, entities or companies on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.

## **YOUR RIGHTS AS A POLICYHOLDER**

If funds are blocked or frozen by us in conjunction with the OFFICE OF FOREIGN ASSETS CONTROL, you may complete an "APPLICATION FOR THE RELEASE OF BLOCKED FUNDS" and apply for a specific license to request their release. Forms are available for download at the OFAC website. See <http://www.ustreas.gov/offices/eotffc/ofac/legal/forms/license.pdf>