COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200
Columbia, SC 29223

POLICYHOLDER:	XYZ Trucking
ADDRESS:	
POLICY NUMBER:	AROAxxxx
POLICY EFFECTIVE DATE:	October 1, 2010 to October 1, 2011
POLICY ANNIVERSARY DATE:	October 1 at12:01 A.M. at the Policyholder's address

In the Policy, "Company", "We", "Us" or "Our" refers to the Insurance Company. "You", "Your", or "Yours" refers to the Policyholder.

The Policy is governed by the laws of the jurisdiction in which it is issued, except to the extent that it may be governed by the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA).

We agree to insure the Policyholder against specific loss and pay the benefits in accordance with all the provisions of this Policy.

Initial Premiums are payable by You to Us or Our agent in the amounts determined by the Policy. The first premium is due on the effective date. Future premiums are due as outlined in the Policy.

This Policy is issued for a term of one year beginning on the Policy Effective Date and continuing until the Policy Anniversary Date. The Policy is automatically renewed, subject to any annual rate adjustment, unless we notify the Policyholder otherwise. The Policy is issued in consideration of the Policyholder's application and the payment of Premiums as provided by the terms of the Policy.

The provisions on the pages which follow form a part of this Policy.

IN WITNESS WHEREOF the Companion Life Insurance Company has caused the Policy to be executed by its President at Columbia, South Carolina.

Trescott N. Hinton, Jr.
President

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE, THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYOLDER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information may be guilty of a felony.

BLANKET OCCUPATION ACCIDENT POLICY
THIS IS A LIMITED POLICY. PLEASE READ CAREFULLY.

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SCHEDULE I - COVERED CLASSES AND APPLICABLE BENEFITS

This Schedule is subject to the terms, conditions, limitations and exclusions set forth in this Policy. It forms a part of the Policy to which the Schedule is attached. The effective date of this Schedule is the Policy Effective Date as shown on the Policy face page.

The Insurance under this Policy applies only to the groups of Eligible Persons described below and only with respect to those coverages for which an amount is shown. Amounts shall apply to each Eligible Person per Accident. This Schedule is subject to all of the provisions limitations, exclusions and definitions of the Policy.

Covered class(es) and Applicable Benefits includes all persons who satisfy the description during the Policy Term.

DESCRIPTION OF COVERAGE AMOUNTS

All active Eligible Persons must be covered subject to the provisions of Section VI - Eligibility and Covered Classes.

COVERAGE SCHEDULE

Maximum Combined Benefit	$1,000,000
Combined Deductible	$500
Combined Benefit Period	110 Weeks
Weekly Accident Indemnity Amount:	70% of weekly earnings up to $600.00 per week
Elimination Period	7days

The maximum Combined Benefit Amount is the maximum benefit payable for Accidental Death & Dismemberment, Accident Medical Expense and Weekly Accident Indemnity per Eligible Person, per Accident subject to the terms, limitations and restrictions of the Policy.

LIMITATIONS OF LIABILITY

We shall not be liable for any amounts in excess of the following limits:

- Accidental Death and Dismemberment is subject to $150,000 per Eligible Person, per Accident maximum.
- Coverage for losses resulting from Acts of Terrorism is limited to $5,000 per incident. See Section XI of the Policy for explanation.
- The Aggregate Limit of Liability is $2,000,000 per accident. Refer to Section X of this Policy for explanation.

ATTACHED PROVISIONAL ENDORSEMENTS:

SECTION II - DEFINITIONS

For the purpose of the Policy:

ACCIDENT means a sudden and unforeseen event causing loss or Injury, which is not due to any fault or misconduct of an Eligible Person, is independent of all other causes and occurs while the Eligible Person is Actively at Work.

ACCIDENTAL BODILY INJURY or INJURY means an Injury suffered by an Eligible Person while Actively at Work that is the direct result of an Accident when such Injury is involuntary and independent of all other causes.

ACTIVELY AT WORK or ACTIVE WORK means an Eligible Person must be:

1. working for you on a Permanent Basis; and
2. performing the material and substantial duties of the Eligible Person's regular job;
   a. At your usual place of business; or
   b. At a location to which Your business requires the Eligible Person to travel; or
   c. While traveling between Your usual place of business and a location to which Your business requires the Eligible Person to travel.

ACT OR ACT OF TERRORIST means an activity that

1. Involves a violent act or an act dangerous to human life, property or infrastructure; and
2. Appears to be intended to
   a. Intimidate or coerce a civilian population; or
   b. Influence the policy of a government by intimidation or coercion; or
   c. Affect the conduct of a government by mass destruction, assassination, kidnapping, or hostage taking.

AIRCRAFT means a device that is used for or is intended to be used for flight in the air.

APPLICATION is the form You completed to request coverage under this Policy.

AMBULATORY SURGICAL CENTER means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an Ambulatory Surgical Center.

BASE ANNUAL EARNINGS means the amount of compensation paid to an Eligible Person including overtime, tips, and commissions. For commissioned Eligible Persons, Base Annual Earnings shall be the average annual earnings over the three (3) year period immediately preceding the date of loss; for commissioned Eligible Persons with less than three years history, an average monthly earning will be calculated and multiplied by twelve to calculate Base Annual Earnings.

BENEFICIARY means the person to whom loss of life benefits will be paid.

COMBINED BENEFIT PERIOD means the amount of time within which benefits must become payable to or on behalf of a Policyholder, Eligible Person or Eligible Person's Beneficiary. The benefit period begins on the date the Accidental Bodily Injury occurred. A separate Combined Benefit Period will start for each Accidental Bodily Injury.

COMBINED BENEFIT AMOUNT is the maximum benefit payable to or on behalf of the Policyholder, Eligible Person or Eligible Person's Beneficiary for Accidental Death and Dismemberment, Accident Medical Expense, and Weekly Accident Indemnity per Accident, subject to the terms, limitations and restrictions of the Policy. The Maximum Combined Benefit Amount is shown in Section I.

COMBINED DEDUCTIBLE AMOUNT means the total amount of Accidental Death and Dismemberment, Accident Medical Expense, and/or Weekly Accident Indemnity benefits that must be paid by the Policyholder for each Eligible Person for each covered Accidental Bodily Injury before benefits are payable under this Policy.

CONTINUOUS TOTAL DISABILITY means **AFTER** the first 110 weeks of any continuous period of disability, an Eligible Person is not able to perform any of the Material and Substantial Duties of an Eligible Person's regular occupation, business or employment which he or she held when the disability began and, for the remainder of any such period of continuous disability, Total Disability shall mean the Eligible Person is not able to perform any of the duties of any occupation for which he or she is reasonable fitted by education, training or experience. Benefits will not be payable for any period of disability during which the Eligible Person is not under the regular and continuous care of a Physician.

CONTRACTOR means a party that enters into an agreement, by written contract or otherwise, to provide services to, or on behalf of, the Policyholder. Eligible contractors must be reported to Us on the Contract Labor Census Form.

CONVALESCENT NURSING FACILITY means an institution or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from an Injury, professional nursing services rendered by a nurse to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities:
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or nurse;
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders; and
7. It is approved and licensed by Medicare. This term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

CONVALESCENT PERIOD means a period of time commencing with the date of confinement of an Eligible Person to a Convalescent Nursing Facility. Such confinement must meet all of the following conditions:

1. Such confinement must commence within fourteen (14) days of being discharged from a Hospital;
2. Said Hospital confinement must have been for a period not less than three (3) consecutive days; and
3. Both the hospital and convalescent confinements must have been for the care and treatment of the same Injury.

A Convalescent Period will terminate when an Eligible Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of an Eligible Person's appearance rather than for the improvement or restoration of bodily functions.

COVERED CHARGES are charges actually incurred for inpatient or outpatient medical care and treatments of the injured Eligible Person.

COVERED CLASS(ES) means an Eligible Person Actively at Work for the Policyholder, who is a member of an Eligible Class defined on the Schedule of Benefits. A Contractor or an employee of a Contractor may be an Eligible Person. Eligible Persons must be identified by the Policyholder or Contractor on the most recent Contract Labor Census Form.

CUMULATIVE TRAUMA means damage to the physical structure of an Eligible Person's body resulting from repetitious physically traumatic activities that occur solely while the Eligible Person is performing the duties of his or her regular job. Cumulative Trauma includes repetitive motion disorders, overuse disorders and Carpel Tunnel Syndrome. It does not include Injury resulting from an Accident or Occupational Disease.

CUSTODIAL CARE means care that is administered for assistance (rather than for training or education) of the patient in performing the activities of daily living. Such activities include, but are not limited to, walking, getting in and out of bed, personal hygiene, feeding, preparing special diets and administering medication. Custodial Care also includes non-acute care for the comatose, semi comatose, paralyzed, or mentally incompetent patient.

ELIMINATION PERIOD means the number of days after the Accidental Bodily Injury has been suffered and an Eligible Person is Totally Disabled, but for which no Weekly Accident Indemnity benefits are payable.

ELIGIBLE PERSON means a person Actively at Work for the Policyholder, who is a member of an Eligible Class defined on the Schedule of Benefits. A Contractor or an Employee of a Contractor is an Eligible Person. All Eligible Persons must be identified by the Policyholder or Contractor on the most recent Contract Labor Census Form.

EXTENDED CARE FACILITY means an institution or distinct part of an institution which:

1. Is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state in which it operates.
2. Is regularly engaged in providing twenty-four (24) hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a Physician; and
6. Provides each patient with active treatment of an Injury or related rehabilitation in accordance with existing standards of medical practice for that condition.

HOME HEALTH CARE AGENCY means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) registered graduate nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or registered graduate nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

HOME HEALTH CARE PLAN means a program for continued care and treatment of an Eligible Person established and approved in writing by the Eligible Person's attending Physician within seven (7) days following termination of a Hospital confinement as a resident patient, and is for the same or related condition for which he or she was hospitalized. The attending Physician must certify that the proper treatment of the Injury would require continued confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPITAL means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to the injured person on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the laws of the jurisdiction in which it is located and pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services;
5. It is a provider of services under Medicare; and
6. It charges patients for its services.

Hospital does not mean a facility operated exclusive for treatment of the aged, drug addicts or alcoholics, or a nursing home.

INCURRED EXPENSES means those services and supplies rendered to an Eligible Person. Such expenses shall be considered to have occurred at the time or date the services or supplies are actually provided.

INPATIENT refers to the classification of Injured Eligible Person, which is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for room and board as a result of such treatment.

INTENSIVE CARE UNIT means a section, ward or wing within the Hospital which is separated from other facilities and;

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill or critically injured patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by nurse or other highly trained Hospital personnel.

MATERIAL AND SUBSTANTIAL DUTIES means duties or job functions which are normally required for the performance of an occupation and which cannot be reasonably omitted or modified. However, if an Eligible Person is normally required to perform Material and Substantial Duties in excess of 40 hours per week prior to becoming Totally Disabled, We will consider the Eligible Person able to perform Material and Substantial Duties at the required pre-disability level if the Eligible Person is working or has the capacity to perform such functions at least 40 hours weekly.

MAXIMUM MEDICAL IMPROVEMENT means based on reasonable medical probability, further material recovery from lasting improvement to an Injury can no longer reasonably be anticipated.

MEDICALLY NECESSARY means that a service, medicine or supply is necessary and appropriate for the diagnosis or treatment of an Accidental Bodily Injury based on generally accepted current medical practice. A service, medicine or supply will not be considered Medically Necessary if it;

1. is provided only as a convenience to an Eligible Person or Physician; or
2. is not appropriate treatment for an Eligible Person's diagnosis or symptoms; or
3. exceeds in scope, duration or intensity, that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not make the service or supply Medically Necessary.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the United States Social Security Amendments of 1965, as then constituted or later amended.

MINOR EMERGENCY MEDICAL CLINIC means a freestanding facility that is engaged primarily in providing minor emergency and episodic medical care to an Eligible Person. A board-certified Physician, a registered nurse, and a registered X-Ray technician must be in attendance at all times that the clinic is open.

The clinic's facilities must include X-ray and laboratory equipment and a life support system. For the purposes of this Policy, a clinic otherwise meeting these requirements but is, in any way, part of a regular Hospital shall be excluded from the terms of this definition.

OCCUPATIONAL DISEASE means a disease that is caused solely from performance of an Eligible Person's regular duties of his or her job and causes damage or harm to the physical structure of the body. It includes other diseases or infections that naturally result from the work-related disease. It does not include ordinary diseases to which the general public is exposed outside the Eligible Person's regular duties of his or her job. It does not include Injury resulting from an Accident or Cumulative Trauma.

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

ORTHOTIC APPLIANCE means an external device intended to correct any defect in form or function of the human body.

OUTPATIENT refers to an Eligible Person who receives medical care, treatment, services or supplies at a clinic, a Physician's Office or at a Hospital, if not a registered bed patient at that Hospital.

PARTIAL DISABILITY/PARTIALLY DISABLED means an Eligible Person's inability to perform one or more, but not all, of the essential duties of his or her occupation.

PERMANENT BASIS when used in reference to Actively at Work or Active Work shall mean anyone who is being reported by the Policyholder or Contractor as an Eligible Person on either; (1)the most recent Employee Census form or (2) the most recent Contract Labor Census Form.

PHYSICIAN means a person who is a licensed doctor of medicine or osteopathy; or is any other licensed health care provider that state law requires to be recognized as a Physician. He or she must be acting within the scope of his or her license; and cannot be the Eligible Person, Eligible Person's Spouse, son, daughter, father, mother, brother or sister.

POLICYHOLDER means the legal entity to which the policy is issued and named on the first page of the Policy. It is also referred to as "You", "Your", and "Yours".

POLLUTION RELATED DISEASE means any systematic disease due to hypersensitivity disorder or atopic disease, other than those directly caused from acute allergic reactions.

PRE-CERTIFICATION means a program whereby prior to incurring Covered Charges due to Hospital admission or Physician treatment, the Policyholder, an Eligible Person or his or her Physician obtains prior authorization from Us or Our representative. Please refer to the Pre-Certification provision in Section III, Accident Medical Expense.

PRE-EXISTING CONDITION OR INJURY means a condition or Injury(ies) for which diagnosis, treatment or care, including prescription, or medical advice was recommended or received within the six (6) month period immediately prior to an Eligible Person's effective date.

PREMIUM DUE DATE means the day of the month on which the premium is due.

REGULAR OCCUPATION means the occupation, business or employment which an Eligible Person was regularly engaged in and which was the source of an Eligible Person's income from the Policyholder when his disability began.

ROOM AND BOARD refers to all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as a condition of Occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SOCPE OF EMPLOYMENT means an activity of any kind or character that involves the furtherance of Your business, trade or profession or the Eligible Person's business, trade or profession at Your regular workplace in furtherance of Your business, trade or profession. Scope of employment does not include an Eligible Person's transportation to and from an Eligible Person's workplace unless:

1. the transportation is furnished as part of the contract of employment, or is paid by You, or the means of such transportation is under Your control; or
2. the Eligible Person is directed in his or her scope of employment to proceed from one place to another place.

TOTAL DISABILITY OR TOTALLY DISABLED means during the first 110 weeks of any continuous period of disability, an Eligible Person is not able to perform any of the Material and Substantial Duties of an Eligible Person's regular occupation, business or employment which he or she held when the disability began and, for the remainder of any such period of continuous disability, Total Disability shall mean the Eligible Person is not able to perform any of the duties of any occupation for which he or she is reasonable fitted by education, training or experience, Benefits will not be payable for any period of disability during which the Eligible Person is not under the regular and continuous care of a Physician.

URGENT CARE CLAIM means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination could seriously jeopardize the life or health of an Eligible Person or the ability of an Eligible Person to regain maximum function or, in the opinion of the Physician with knowledge of the Eligible Person's medical condition would subject the Eligible Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

USUAL AND CUSTOMARY CHARGE means the usual charge made by a Physician or other provider of services, supplies, medications or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area for similar type coverage. The term "area" means a county or such other area as is necessary to obtain a representative cross-section of such charges.

WEEKLY EARNINGS means Base Annual Earnings divided by 52. If Weekly Earnings vary from week to week, the average pay for the 13 weeks immediately preceding the Accident shall be used to determine the Weekly Accident Indemnity.

SECTION III - DESCRIPTION OF COVERAGE

ACCIDENT MEDICAL EXPENSE (AME)

The benefits described in this section apply only to Accident Medical Expense coverage. The benefits described in this section are subject to the other terms and conditions contained in this Policy, including definitions and exclusions.

Covered charges are charges actually incurred for the inpatient or outpatient medical care and treatment of an Eligible Person as listed below. The medical care and treatment must be ordered by a Physician and deemed Medically Necessary by Us. In no event will We pay a charge which is in excess of the Usual and Customary Charge for the service, the supplies or the equipment which are needed for such care and treatment. Covered Charges shall be deemed to have been incurred on the date the treatment was rendered or the service was given. Types of covered expenses include:

1. Charges made by a Hospital for:
   a. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit. Charges made by a Hospital having only private rooms will be paid at 90% of the private room rate; and
   b. Necessary services and supplies other than room and board furnished by the Hospital, including inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, physical therapy treatments, hemodialysis, x-ray, and Linear therapy.
2. Charges made by a Convalescent Nursing facility for the following services and supplies furnished by the facility during the first sixty (60) days of convalescent confinement in any one Convalescent Period. Only charges incurred in connection with convalescence from the Injury, for which an Eligible Person is confined, will be eligible for benefits. These expenses include:
   a. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board charge allowed will not exceed the facility's average semi-private charges or an average semi-private rate made by a representative cross section of similar institutions in the area;
   b. Medical services customarily provided by the convalescent facility, with the exception of private-duty or special nursing services and Physician's fees; and
   c. Drugs, biological solutions, dressings and casts furnished for use during the Convalescent Period, but no other supplies.
3. Fees for the services of a legally qualified Physician for medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations;
4. Fees for a nurse performing private duty nursing;
5. Fees for services rendered by a licensed physical therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Injury;
6. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury, or due to surgery performed on account of an Injury;
7. Charges for professional ground ambulance services to the nearest facility where emergency care or treatment is rendered;
8. Charges for drugs requiring the written prescription of a licensed Physician; such drugs must be necessary for the direct treatment of an Injury;
9. Charges for X-rays, microscopic tests and laboratory tests;
10 Charges for radiation therapy or treatment;
11. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components, if replaced;
12. Charges for oxygen and other gases and their administration;
13. Charges for electrocardiograms, electroencephalograms, pneuma-encephalogram, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians and Medically Necessary;
14. Charges for the cost and administration of an anesthetic;
15. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, initial pair of corrective shoes, or other necessary medical supplies with the exception of dental braces;
16. Charges for the rental of a wheelchair, hospital bed or iron lung or other durable medical equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less;
17. Charges for artificial limbs, eyes, larynx, or Orthotic Appliances but not the subsequent replacement of such items;
18. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic when treatment has been rendered;

19. Charges made by a Home Health Care Agency for care in accordance with the Home Health Care Plan are covered up to a maximum of sixty (60) days. Such expenses include;
    a. Part-time or intermittent nursing care by a nurse who is under the direct supervision of a registered nurse;
    b. Home health aides; and
    c. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this plan if an Eligible Person had remained in the Hospital.

    Specifically excluded from coverage under this benefit are the following:
    a. Services and supplies not included in the Home Health Care Plan; and
    b. Services of a person who ordinarily resides in the home of an Eligible Person, or is a close relative of an Eligible Person; and
    c. Transportation services.
20. Occupational therapy will be covered up to $10,000 in benefits per Covered Accidental Bodily Injury.

When an Accidental Bodily Injury to an Eligible Person results in Covered Charges, We will reimburse the Physician, Provider or facility directly on behalf of the Policyholder, for the cost of those Charges up to the Combined Benefit Amount shown in Section I, less any payments made to or on behalf of the Policyholder, Eligible Person, or Eligible Person's Beneficiary for any other benefits under the Policy for the same Accident. The Covered Charges must be the direct result of an Accidental Bodily Injury.

We will not pay any benefits unless the first Covered Charges that are caused by the Accident occur within 30 days of the Accident.

Coverage must be in force under the Policy at the time of an Eligible Person's Accident.

Accident Medical Expense benefits will cease once the Eligible Person reaches the Maximum Medical Improvement.

If an Eligible Person receives benefit payments and then is subsequently no longer Totally Disabled and receives no medical treatment for Injuries for six (6) consecutive months, no additional benefits will be payable for that Injury. Benefits would be payable to the Eligible Person only if a new Accident occurs and the Injury is due to entirely unrelated causes.

We will pay benefits for Covered Charges provided:

1. The Combined Deductible Amount, if any, as shown in Section I has been fulfilled; and
2. Covered Charges for an Accidental Bodily Injury are incurred within the Combined Benefit Period shown in Section I; and
3. Such Covered Charges are Medically Necessary and charges are Usual and Customary for such services in the geographic area where the service was performed; and
4. The total amount payable for any one Eligible Person as a result of one Accident for all Injuries does not exceed the maximum Combined Benefit Amount shown in Section I, less any payments made for other benefits under this Policy that are payable as a result of the same Accident.

PRE-CERTIFICATION

Pre-Certification is designed to assure that hospital admissions and lengths of stay, surgery and other medical services are Medically Necessary by having Our medical staff determine Medical Necessity.

An Eligible Person, the Eligible Person's Physician, or the Policyholder must request Pre-Certification at least 3 days prior to a non-emergency admission or treatment. If admission or treatment is for Emergency Care, notice to Us must be given (1) within 24 hours after it occurs; (2) on the first business day after admission or treatment on a weekend or legal holiday; or (3) the earliest reasonable time thereafter.

We may consult with the Physician, Hospital or other facility to determine if the hospital stay or treatment is required for the Injury. We may decide that the treatment the Eligible Person requires could be provided just as effectively through a less expensive treatment plan. If We determine that treatment can be provided though a less expensive treatment plan, the Eligible Person and/or the Policyholder will be notified of that decision. If the Eligible Person proceeds with the treatment plan without our approval or if we are not asked for Pre-Certification or given notice, the benefit will be reduced by $500.

EXTENSION OF BENEFITS

If an Eligible Person's coverage terminates because the Eligible Person terminates employment or his or her engagement, or this Policy is terminated, coverage will be extended for Covered Charges that result from an Injury that occurred before the date of termination.

Coverage for the extension of benefits will be limited to the lesser of the payment of the Combined Benefit Amount or payment for the Combined Benefit Period.

SECTION IV - DESCRIPTION OF COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT - EXTENDED DISMEMBERMENT (A D & D)

The benefits described in this section apply only to the Accidental Death and Dismemberment - Extended Dismemberment benefits. The benefits in this section are subject to the other terms and conditions contained in this Policy, including definitions and exclusions.

When, as the result of an Accidental Bodily Injury, an Eligible Person suffers any one of the losses listed below, We will pay the applicable benefit to an Eligible Person, in the case of Dismemberment, or the Eligible Person's Beneficiary in the case of Death provided:

1. The Combined Deductible Amount, if any, as shown in Section I has been fulfilled; and
2. The Covered Loss occurs within the Combined Benefit Period shown in Section I; and
3. The total amount payable to any one Eligible Person as a result of one Accident for all Injuries does not exceed the maximum Combined Benefit Amount shown in Section I, less any payments made for the other benefits under this Policy that are payable as a result of the same Accident, except that the amount payable for Accidental loss of life is guaranteed to be no less than fifteen percent (15%) of the Accidental Death and Dismemberment benefit amount shown in Section I, regardless of the total amounts paid for any other benefits under this Policy.

Coverage must be in force under the Policy for the Eligible Person at the time of the Accident. We will pay only one benefit for any loss. If more than one loss occurs due to the same Accident, We will pay the larger amount for any one of the losses. Coverage for Accidental Death and Dismemberment is subject to a per Eligible Person, per Accident maximum listed under "Limitations of Liability" in Section I of the Policy.

Loss Of	Benefit
Life	100% of A D & D Benefit Amount
Both Hands	100% of A D & D Benefit Amount
Both Feet	100% of A D & D Benefit Amount
Sight of Both Eyes	100% of A D & D Benefit Amount
One Hand and One Foot	100% of A D & D Benefit Amount
One Hand and Sight of One Eye	100% of A D & D Benefit Amount
One Foot and Sight of One Eye	100% of A D & D Benefit Amount
Speech and Hearing in Both Ears	100% of A D & D Benefit Amount
Use of Both Arms and Both Legs	100% of A D & D Benefit Amount
Use of Both Arms or Both Legs	75% of A D & D Benefit Amount
Use of One Arm and One Leg	75% of A D & D Benefit Amount
Speech	50% of A D & D Benefit Amount
Hearing in Both Ears	50% of A D & D Benefit Amount
One Hand	50% of A D & D Benefit Amount
One foot	50% of A D & D Benefit Amount
Sight of One Eye	50% of A D & D Benefit Amount
Use of One Arm or One Leg	50% of A D & D Benefit Amount
Thumb & Index Finger of the Same Hand	25% of A D & D Benefit Amount

A BENEFIT IS NOT PAYABLE FOR BOTH LOSS OF THUMB AND INDEX FINGER OF SAME HAND AND LOSS OF ONE HAND FOR INJURY TO THE SAME HAND AS THE RESULT OF ANY ONE ACCIDENT.

LOSS with regards to:

1. Life means a death, which is the direct result of an Accidental Bodily Injury;
2. The hand means the actual, permanent and complete severance of all four entire fingers or the actual, permanent and complete severance at or above the wrist joint;
3. The foot means the actual, permanent and complete severance at or above the ankle joint;
4. Sight means the total and irrevocable loss of sight;
5. Speech and/or hearing means the total and irrevocable loss of the entire faculty of hearing aid/or speech; and
6. Thumb and index finger means the actual, permanent and complete severance through or above the metacarpophalangeal joints.

LOSS OF USE means the total loss of movement or total feeling in the arm including the hand and/or leg including the foot. This loss must be determined by a Physician to be complete and irrecoverable.

SECTION V - DESCRIPTION OF COVERAGE

WEEKLY ACCIDENT INDEMNITY (WAI)

The benefits described in this section apply only to Weekly Accident Indemnity benefits. The benefits described in this section are subject to the other terms and conditions contained in this Policy, including definitions and exclusions.

When an Accidental Bodily Injury results in the Total Disability of an Eligible Person, We will pay the benefits described in Section I provided:

1. The Combined Deductible Amount, if any, as shown in Section I has been fulfilled; and
2. The Covered Loss occurs within the Combined Benefit Period shown in Section I; and
3. The total amount payable for any one Eligible Person as a result of one Accident for all Injuries does not exceed the maximum Combined Benefit Amount shown in Section I, less any payments made for other benefits under this Policy that are payable as a result of the same Accident.

Total Disability must commence within one year of the date of the Accident, which caused the Total Disability. Coverage must be in force for the Eligible Person at the time of the Accident. The Eligible Person must be Totally Disabled and under the regular and continuous care and treatment of a Physician. The Eligible Person must be able to provide proof of Total Disability and that it resulted from an Accidental Bodily Injury.

If all of the above conditions are met, We will pay to the Policyholder, after the Elimination Period shown in Section I has been met, an amount equal to 70% of the Eligible Person's Weekly Earnings, when combined with other disability plans that may be in force at the time of the Accident, or the Weekly Accident Indemnity shown in Section I, if lesser. The benefit will be paid each week, after the Elimination Period has been met, during the Combined Benefit Period shown in Section I. If the disability does not last a week beyond the Elimination Period, We will pay one seventh of the weekly benefit for each day an Eligible Person is disabled beyond the Elimination Period stated in Section I, if any.

1099 CONTRACTOR WAGE CLARIFICATION

Notwithstanding anything to the contrary, the Weekly Accident Indemnity Benefit (WAI) for an Eligible Person who is a Contractor who receives a 1099 or similar wage reporting document, rather than a W-2 will be calculated as follows:

33% of such Contractor's Weekly Earnings, as calculated below, will be multiplied by 70%. For such Contractors only, Weekly Earnings will be determined as follows:

1. We will take the gross income he or she received the prior year, as shown on his or her federal income tax return with schedules or 1099's or similar wage reporting documents, and divide by number of weeks worked with no regard to prior occupation. He or she will have to provide proof, satisfactory to Us, of the number of weeks worked if claiming less than one (1) year.
2. If he or she did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but has worked as a Contractor in the current year We will take the gross income earned in the current year and divide by the number of weeks worked in the current year. (Such person will have to produce proof, which is satisfactory to Us, of his or her gross income and the number of weeks worked.)

The WAI benefit will not be paid beyond:

1. the date the benefit is paid for the Combined Benefit Period shown in Section I.
2. the date of the death of the Eligible Person.
3. the date the Eligible Person no longer qualifies as Totally Disabled.
4. the date the Eligible Person returns to Active Work or is released to return to work by the treating physician.

When the Weekly Indemnity in combination with the amounts for which an Eligible Person qualifies to receive under: (1) Social Security (including payments to eligible dependents); (2) Workers' Compensation; (3) any State Compulsory Disability Benefits Law; or (4) any disability, retirement, or other income benefits provided through the Policyholder exceeds 100% of Weekly Earnings immediately preceding Total Disability, the amount which is in excess of 100% will be deducted from the Weekly Accident Indemnity payable under this Policy.

If an Eligible Person receives benefit payments and then is subsequently no longer Totally Disabled and receives no medical treatment for Injuries for six (6) consecutive months, no additional benefits will be payable for that Injury. Benefits would be payable to that Eligible Person only if a new Accident occurs and the Injury is due to entirely unrelated causes.

Discontinuance of the Policy will not affect the benefits payable for a Total Disability that began while the Policy was in force.

The Eligible Person must submit proof of continued Total Disability on a periodic basis. This may be done as often as We consider necessary and reasonable, but in no case more than once every three months. Failure to submit the requested proof will result in termination of benefit payments until such proof is received.

No Coverage is provided for Partial Disability or any disability resulting from a cause other than Accidental Bodily Injury.

BENEFITS DURING REHABILITATION

For the purpose of this provision, Rehabilitation means the conditional participation of an Eligible Person in a program with the Policyholder and Us, under the supervision of the attending Physician, to return the Eligible Person to gainful employment.

If the Eligible Person is receiving benefits related to the Total Disability of such Eligible Person under this coverage, the Eligible Person meets the definition of Partially Disabled and the Eligible Person makes advance written request or has been evaluated by Us to be a candidate for rehabilitation, We may consider him or her on "rehabilitation status" for a limited duration. We will determine and notify the Eligible Person in writing of the specific duration and conditions of such rehabilitation status.

We will continue to pay Weekly Accident Indemnity benefits to the Eligible Person while he or she is employed as part of the rehabilitation plan provided the Eligible Person is not working more than twenty (20) hours per week.

The Weekly Accident Indemnity will be payable only to the extent that the Eligible Person's total income during rehabilitation does not exceed 100% of his or her Weekly Earnings immediately preceding Total Disability when the benefit is combined with such earnings.

The benefits: (a) will be payable for an initial 3 month period while such rehabilitation continues: and (b) may be extended for additional 3 month periods, up to a maximum of 12 months in any one period of Total Disability.

SECTION VI - ELIGIBILITY AND COVERED CLASSES

COVERED CLASS(ES)

Covered Class(es) are described in Section I

ELIGIBILITY

An Eligible Person will be eligible for coverage under this Policy on the later of:

1. The date the person becomes a member of a Covered Class; or
2. The effective date of the Policy.

An Eligible Person's coverage shall not become effective if the person is not Actively at Work on the date coverage would otherwise become effective. The Eligible Person's coverage will become effective on the date of his or her return to Active Work.

SECTION VII - PREMIUM

The first premium is due on or before the effective date. All other premiums must be paid on or before the Premium Due date.

The Policyholder will report the actual number of Eligible Persons on a monthly basis and will remit the premium due to Us based upon this information.

The Policyholder will be notified in writing of the premium rate on or before the effective date of this Policy, and thereafter, when the premium rate is changed. We may change the premium rate on any Premium Due Date:

1. When coverage or Covered Classes are changed under the Policy.
2. Not more than once in any twelve month period:
3. If the number of Eligible Persons changes
4. If there is a change in the factors bearing on the risk assumed.
5. If any action of government changes Our liability under this Policy.

No premium rate changes will become effective unless we notify the Policyholder at least 60 days before the effective date of such change. Premium rate changes may take effect on an earlier date when both the Policyholder and We agree in writing.

INCORRECT PREMIUM PAYMENT

Premiums paid in error, for a person who is not covered, will be refunded. Such refunds are without interest and must be requested by the Policyholder. Except for fraud, premium adjustments or refunds, changes will be made only for the current and previous Policy year.

GRACE PERIOD

After the first premium, any premium not paid by its due date is in default. For all premiums not paid when due, there is a thirty-one day Grace Period. You may pay a due premium during this time without interruption of coverage. If, at the end of the Grace Period, We have not received such due and unpaid premium, the insurance under this Policy shall terminate without notice effective on the last day for which premium was paid.

PREMIUM AUDIT

We receive the right to inspect or review all of the records, payroll and employment, of the Policyholder relating to this insurance at any reasonable time while the Policy is in force or within two years after its termination. The Policyholder shall make necessary records available to Us at Our request. If the final settlement of all premium payments and claims liability under the Policy extends for more than two years after its termination, Our right to audit shall extend until the final settlement is made.

SECTION VIII - CLAIMS

REQUIRED NOTICE OF ACCIDENT

Written notice of an Accident that may or may not result in a claim for benefits must be given to Us: (a) as soon as reasonably possible but no later than 30 days after the date of the Accident; and (b) on Our standard Report of Injury form or on an acceptable form that provides Us with the same facts of the Accident, releases and authorizations that would be provided by Our form.

Failure to submit written notice of an Accident to Us within 30 days of an Injury will result in denial of a claim for benefits.

SUBMISSION OF CLAIMS

We must receive written submission of claims for benefits within 91 days of;

1. the date of treatment for Accident Medical Expense claims;
2. the date of death or dismemberment for Accidental Death & Dismemberment claim; and
3. the last date of the payroll period for which benefits are being claimed for Weekly Accident Indemnity claims.

If it is not possible to submit a claim within the timeframe specified above, it must be given as soon as reasonably possible. In no event, other than in the absence of legal capacity, may submission of a claim for benefits be given after one year from the time such submission is otherwise required. Failure to submit a claim to Us within the timeframe specified above will result in denial of a claim for benefits.

TIME OF DETERMINATION OF CLAIMS

For Accident Medical Expense claims, We will notify the Eligible Person or Policyholder of Our claim decision within 30 days after Our receipt of due proof of loss. If more time is needed due to matters beyond Our control, We may extend this determination period for 15 days. We will notify the Eligible Person or Policyholder of this extension in writing before the end of the initial 30-day review period. The notification will include the circumstances requiring the extension and the expected date of determination. If the claim is an Urgent Care Claim, We will notify the Eligible Person or Policyholder of Our claim decision within 72 hours after We receive the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Policy. In the case of such failure, We will notify the Eligible Person or Policyholder within 24 hours after we receive the claim of the specific information necessary to complete the claim. The Eligible Person will have 72 hours to provide the specified information.

For Weekly Accident Indemnity and Accidental Death and Dismemberment claims, We will notify the Eligible Person or Policyholder of Our claim decision within 45 days after Our receipt of due proof of loss. If more time is needed to matters beyond Our control, We may extend this determination period for 30 days. We will notify the Eligible Person or Policyholder of this extension in writing before the end of the initial 45-day review period. The notification will include the circumstances requiring the extension and the expected date of determination. If more time is still needed to make a claim determination, We will send the Eligible Person or Policyholder written notice during the initial 30 day extension stating the special circumstances that require an additional 30 days. The Eligible Person will have 45 days to provide any additional information requested.

For all claim types, if the claim is wholly or partly denied Our notice will include:

1. Reasons for such denial;
2. Reference to Policy terms and conditions on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the right to request that We review Our decision;
5. A description of Our review procedures, time limits and notice of the Policyholder's right to bring civil action.

The Policyholder may request that We review Our denial of all or part of the claim. This request must be in writing and must be received by Us no more than 180 days after the Policyholder receives notice of Our claim decision. As part of this review, the Policyholder may:

1. Send Us written comments, documents, records, and other information he or she would like Us to review;
2. Request and receive, free of charge, copies of all non-privileged documents, records and other information relevant to the claim to review: or
3. Provide Us with other information of proof in support of the claim.

We will review the claim and all comments, documents, records and other information submitted promptly after receiving the Policyholder's request. In the case of Urgent Care Claims, We will advise the provider, Eligible Person or Policyholder of the results of Our review within 72 hours after We receive the request for review. For all other claims, We will advise the Policyholder of the results of Our review within 45 days after We receive the request, or within 90 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to Policy terms and conditions on which the decision was based, and notice to the Policyholder's right to bring a civil action.

Any unpaid Accident Medical Expense or Weekly Accident Indemnity amounts due at an Eligible Person's death may, at Our option, be paid in one lump sum to the Eligible Person's Beneficiary or estate. Any balance remaining unpaid at the termination of the Combined Benefit Period will be paid immediately upon receipt of due written proof.

If an Eligible Person incurs a loss on or before the Policy terminates, benefits for that loss will be paid on the same basis that benefits would have been payable had the Policy not been terminated, subject to all other provisions of the Policy.

PAYMENT OF CLAIMS

Subject to the limitations or provisions of the Policy, all benefits payable as a result of loss of life shall be payable to the Beneficiary or Beneficiaries of the Eligible Person in accordance with the designation made by the Eligible Person for this insurance and subject to the limitations or provisions of the Policy. If, on the date the Eligible Person dies, there is no named Beneficiary or no surviving named Beneficiary, We will pay benefits to the person or persons who are in the first of the following classes to survive the Eligible Person:

1. the Eligible Person's spouse; or if none
2. the Eligible Person's children, including legally adopted children; or if none,
3. the Eligible Person's parents; or if none
4. the Eligible Person's brothers and sisters; or if none,
5. the executors or administrators of the Eligible Person's estate.

In determining such person or persons, We may rely upon an affidavit by a member of any of the classes of preference beneficiaries. Payment based upon such affidavit shall be full acquittance hereunder unless, before such payment is made, We have received at Our Home Office, or the office of Our designated Administrator written notice of valid claim by some other person. If two or more persons become entitled to benefits as preference beneficiaries, they shall share equally. Any other accrued indemnity unpaid at the Eligible Person's death may, at Our option, be paid to the designated Beneficiary or to such estate.

Payment of an Eligible Person's life benefit will be made to a duly appointed guardian or other legally appointed representative of the Beneficiary if:

1. the Beneficiary is a minor; or
2. in Our opinion, the Beneficiary is not legally capable of giving a valid receipt and discharge for payment.

Accident Medical Expense indemnities shall be payable, on behalf of the Policyholder, to the Physician, provider or facility and Weekly Accident Indemnities shall be payable to the Policyholder.

RIGHTS OF RECOVERY

Whenever benefit payments have been made by Us in excess of the maximum amount of payment required under this Policy, We shall have the right, exercisable alone and in Our sole discretion, to recover such excess payments.

SECTION IX – EFFECTIVE DATE, CHANGES IN COVERAGES AND TERMINATION DATE

EFFECTIVE DATE FOR THE POLICYHOLDER

This Policy is effective for the Policyholder on the date shown on the face page of the Policy provided the premium has been paid.

EFFECTIVE DATE FOR THE ELIGIBLE PERSON

An Eligible Person's coverage will be effective on the later of:

1. the effective date of this Policy;
2. the date the person meets the eligibility requirements.

CHANGES TO THE POLICY

Changes to this Policy are subject to all of the following:

1. This Policy may be amended or altered at any time by written notification to the Policyholder.
2. We may, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy at Our discretion or to comply with any applicable requirements of:
   a. the Internal Revenue Service; or
   b. any state or other federal law or regulation.
3. Changes to this Policy may be made without the approval of the Policyholder, an Eligible Person or Beneficiary.
4. Only an Officer of the Company has the authority to amend, alter, waive or change in any manner, the provisions of this Policy. The changes must be in writing and signed by such Officer of the Company. We will not be bound by any promise or representation made by or to any agent or person other than the authorized Officer.

TERMINATION OF POLICY

This Policy will remain in effect only for the period shown on the face page of this Policy if premium is paid as required, unless We have agreed in writing to further extend coverage under this Policy. If premiums are not paid, there is a Grace Period (see Section VII). This Policy shall terminate if:

1. The Policyholder gives Us written notice 31 days prior to the date premium is due that this Policy shall be canceled on that premium due date; or
2. We have given notice to the Policyholder that We wish to cancel coverage on the next premium due date. Notice must be given to the Policyholder at the last known address at least 60 days prior to the date of cancellation.
3. The Policyholder moves it's business to a state where We are not able to offer this insurance for sale; or
4. The Policyholder commits fraud or material misrepresentation in applying for or obtaining coverage or benefits under this Policy.

For conditions 1. and 2. above, under no circumstances will a termination be retroactive or dated back prior to the 31-day notice date.

TERMIATION OF ELIGIBLE PERSON'S COVERAGE

Eligible Person's will cease to be eligible for Occupational Accident benefits on the earliest of the following dates:

1. the date this Policy terminates;
2. the last day of the Policy term for which premiums have been paid;
3. the date an Eligible Person no longer meets eligibility requirements as stated in this Policy;
4. the first day an Eligible Person no longer meets Our definition of Actively at Work, unless the Extension of Benefits applies.

TERMINATION OF BENEFITS

Benefits will cease on the earliest of the following dates:

1. with respect to Accident Medical Expense Benefits, the date an Eligible Person reaches Maximum Medical Improvement;
2. the date the Eligible Person fails to fully and completely follow the advice of and/or the course of medical treatment prescribed by the treating Physician and keep all scheduled appointments to fulfill the prescribed medical plan. This shall include the Eligible Person's failure or refusal to attend an independent medical examination requested by Us;
3. the date the Eligible Person commits fraud or material misrepresentation in applying for or obtaining benefits under this Policy. This shall include, but not be limited to, filling a fraudulent claim or misrepresentation of identity in obtaining coverage or benefits with the Policyholder.

SECTION X – AGGREGATE LIMIT OF LIABILITY ANY ONE ACCIDENT

Our Aggregate Limit of Liability is shown in Section I. The amount shown is the total amount We will pay to all Eligible Persons that are in any one common Accident. If this amount cannot pay the full amount of each claim for each Eligible Person, the amount of each claim will be paid in the same proportion that each claim has to the Aggregate Limit of Liability.

SECTION XI – LIMIT OF LIABILITY FOR TERRORISM ACTS

Our Limit of Liability for losses which result from Acts of Terrorism is $5,000 per incident. If this amount cannot pay the full amount of each claim for each Eligible Person, the amount of each claim will be paid in the same proportion that each claim has to the Limit of Liability for Terrorism Acts.

SECTION XII – EXCLUSIONS

No benefits will be provided under this Policy, with respect to Accident Medical Expense, Accidental Death & Dismemberment or Weekly Accident Indemnity:

1. which were incurred prior to the Effective date of coverage under the Policy or after coverage is terminated, unless Extension of Benefits applies;
2. incurred as a result of revolt, war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;
3. incurred for which Eligible Person or Policyholder is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage. This Policy will not create such an obligation to pay (except charges paid under Medicaid);

4. resulting from or occurring during the commission or attempted commission of a crime by the Eligible Person; or while engaged in an illegal act, illegal occupation or felonious act or aggravated assault or due to taking part in a riot, rebellion, civil disturbance or insurrection;
5. incurred in connection with committing or attempting to commit suicide or any intentionally self-inflicted Injury;
6. incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or expenses actually incurred by other persons;
7. incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, including that portion of breast surgery which involved the implanting or injecting of any substance into the body for restoring breast shape, except for charges which result from an Injury, which occurs while the Eligible Person is covered under the Policy. Also, this exclusion shall not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury, sustained while covered under the Policy.
8. incurred in connection with services and supplies which are not necessary for the direct treatment of the Injury, or are in excess of Usual and Customary charges, or are not recommended and approved by a Physician, unless specifically shown as covered expenses elsewhere in the Policy;
9. for services, supplies, medicines or treatments, including surgery, which are considered experimental or research by nature, and not recognized by the American Medical Association or the Food and Drug Administration as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Injury, or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
10. for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a close relative of the Eligible Person, or resides in the Eligible Person's household;
11. incurred outside the United States if the Eligible Person traveled to such a destination for the sole purpose of obtaining medical service, drugs or supplies; or for services or supplies not considered legal in the United States;
12. for routine physical examinations or tests not connected with the actual Injury;
13. for Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician; benefits will be paid only for eligible charges incurred for an Eligible Person under the direct care of a Physician;
14. incurred in the connection with eye refractions, the purchase or fitting of eyeglasses (with the exception of eye wear to be worn in connection with the Eligible Person's assigned job task), contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of a hearing aid or eyewear if the loss of hearing or eyesight is a result of a surgical procedure performed as a result of an Injury, while coverage is in effect;
15. incurred for treatment on or to the teeth, gums, the nerves or roots of the teeth, gingival tissue or alveolar processes or supplies used in such treatment or for dental appliances; however, benefits will be payable for charges incurred for treatment required because of Injury, to natural and sound teeth sustained while covered under the Policy. Such expenses must be incurred within six (6) months of the date of the Accident and shall not, in any event, be deemed to include charges for treatment for the repair or replacement of a denture;
16. for any Accident that occurs while an Eligible Person has been determined to be illegally intoxicated, or under the influence of any alcohol, narcotic, barbiturate or hallucinogen unless administered on the advice of a Physician and taken in accordance with the prescribed dosage. The injured Eligible Person may by subject to drug testing at an approved facility at the time of the accident;
17. for professional nursing services, if rendered by other than a nurse unless such care is vital as a safeguard of the Eligible Person's life, and unless such care is specifically listed as a covered expense elsewhere in the Policy;
18. in connection with ptomaine or bacterial infection other than bacterial infection occurring as a consequence of a covered accidental cut or wound;
19. with regard to aircraft, unless We have agreed to cover any of the hazards listed in a-f below, the Policy shall not cover:
    a. boarding, alighting from, riding or being struck by any aircraft owned, operated or leased by You, the Eligible Person or a member of the Eligible Person's household;
    b. riding as a pilot, operator or crewmember in any aircraft;
    c. flying in any aircraft which is rocket propelled;
    d. flying in any aircraft being used for aerobatics, racing or an endurance test;
    e. crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental cause;
    f. flying when a special permit or waiver from the proper authority has to be issued.
20. incurred while traveling to and from work;
21. incurred while practicing for or participating in organized competitive games;
22. incurred while driving in any race or speed contest or while testing any vehicle on a track or speedway;
23. incurred for or in connection with Custodial Care, hydrotherapy, education or training, or work hardening;

24. incurred for Pre-Existing Condition or Injury. This exclusion will not apply after the Eligible Person has been: (a) free from treatment, including prescriptions, for six (6) consecutive months; or (b) listed as an Eligible Person of the Policyholder for this benefit for twelve (12) consecutive months;
25. incurred for treatment of Cumulative Trauma, Occupational Disease, repetitive motion or overuse disorders, Carpal Tunnel Syndrome, or any other diseases or disorders that are caused or arise out of or aggravated in the course of employment;
26. incurred for any mental, emotional or psychological condition not directly attributable to an organic brain syndrome that results directly from an Injury, independent of disease, bodily infirmity or other cause;
27. incurred for any and all types of Herpes, Simplex Type 2 Genital Herpes, Syphilis, Gonorrhea, psychiatric and/or mental and/or emotional disease, distress or disorder and Pollution Related sickness, disease or death;
28. incurred by independent contractors or sub-contractors who are not Your Eligible Persons;
29. which result from or are related to nuclear incidents or radioactive contamination;
30. for fees associated with missed or cancelled Physician appointments;
31. for any Accident that occurs while the Eligible Person is not in the Scope of Employment.

SECTION XIII – GENERAL PROVISIONS

BUSINESS TRAVEL

We will cover an Accidental Bodily Injury suffered by an Eligible Person while traveling on business of the Policyholder to a destination other than the Eligible Person's usual place of work.

With regards to air travel, the Eligible Person must be riding, boarding, exiting or being struck by:

1. A civil aircraft with a valid current Airworthiness Certificate. The aircraft must be piloted by a person with a valid current Pilot's Certificate. The Certificate must have the proper rating for the type of flight and aircraft used; or
2. A transport aircraft run by the military airlift command for the United States or a similar air transport service run by a foreign country.

All losses related to travel are subject to the Policy Exclusions including those Exclusions related to aircraft.

ENTIRE CONTRACT

This Policy is the complete contract. It consists of:

1. this Policy and any attached riders, endorsements or amendments; and
2. the Application, which is attached to and made part of this Policy.

No agent may change this Policy in any way. Only an officer of the Company can approve a change. Any change must be shown in this Policy in writing.

INCONTESTABILITY

Any statements made in the Application are representations and not warranties. Unless contained in a written instrument, a copy of which has been furnished to the Policyholder, Eligible Person or Beneficiary, no statements will be used:

1. to contest or void coverage under this Policy.
2. to deny or reduce benefits.
3. in defense to a claim under this Policy.

Further, no statement will be used in a contest after coverage has been in force for two years.

MONTHLY REPORTING

The Policyholder must report total number of Eligible Persons with each monthly installment.

Premium payments and documentation shall be available for audit subject to the Premium Audit provision of Section VII of this policy.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our own expense, have the right to have an Eligible Person examined when and as often as reasonable necessary while a claim is pending or ingoing, but in no case more than once every three months. Failure to submit to the examination will result in termination of benefits. We also can have an autopsy performed (at Our expense) unless prohibited by law.

CERICAL ERROR

Inadvertent clerical errors (whether by the Policyholder or by Us) will not change the benefits or provisions of the Policy. Upon discovery of such error, any needed adjustments will be made.

LEGAL ACTION

No legal action may be brought by You to recover on the Policy within sixty days after written proof of loss has been given as required by the Policy. No such action may be brought after three years from the time written proof of loss is received. If the time limitation stated in the Policy is less than that permitted by the law of the state, such limitation is extended to agree with the minimum period permitted by law.

DESIGNATION OR CHANGE OF BENEFICIARY:

ASSIGNMENT

The right of designation or change of beneficiary is reserved to the Eligible Person. The permission of the Beneficiary shall not be required for the Eligible Person to change his or her Beneficiary or his or her coverage under the Policy. No change of Beneficiary shall be binding on Us until the original or a duplicate thereof is received by the designated custodian of Beneficiary records. No assignment of interest shall be binding on Us until the original or a duplicate thereof is received by Us.

We assume no responsibility for the validity of such designation or change of Beneficiary or assignment.

RECORDS MAINTAINED

You agree to keep records of the Eligible Persons showing, with respect to each, the essential particulars of this insurance.

WORKERS' COMPENSATION

This is not a Policy of Workers' Compensation insurance. The Policyholder does not become a subscriber to the Workers' Compensation system by purchasing this Policy, and if the Policyholder is a non-subscriber, the Policyholder loses those benefits which would otherwise accrue under the Workers' Compensation laws. The Policyholder must comply with the Workers' Compensations law as it pertains to non-subscribers and the required notifications that must be filed and posted.

RIGHT OF SUBROGATION AND REFUND

If the Eligible Person's Injury is caused by a third party's wrongful act or negligence, the following provisions shall apply.

1. In order to receive any Policy benefits for that Injury the Eligible Person or the Eligible Person's legal representative (or in the case of the Eligible Person's death, the Eligible Person's estate) agree: (1) that the Policyholder and/or We will have subrogation rights to any recovery (irrespective of whether there is recovery from the third party of the full amount of all claims against the third party) or first right of recovery against that third party; (2) not to take any action which would prejudice the Policyholder's and/or Our subrogation rights; (3) to cooperate in doing what is reasonably necessary to assist the Policyholder and/ or Us in any recovery, including, but not limited to, signing and delivering documents to evidence or secure the right of recovery; and (4) to include in any liability claim against any third party any benefits payable to or on behalf of the Injured party under this Policy.
2. The Policyholder and/or We will have subrogation rights only to the extent of the Policy benefit paid because of that Injury or Death.
3. The right of subrogation shall extend to any third party including the at-fault party, his or her insurer or any carrier providing uninsured or underinsured motorist coverage.
4. Subrogation rights of the Policyholder and/or Us under this Section will not be jeopardized merely because the Policyholder and/or We fail to recognize any right of subrogation until after paying Policy benefits or if the Policyholder and/or We recognize the right of subrogation, but fail to obtain the necessary consent before paying Policy benefits. Any Policy benefits paid to the Eligible Person, his legal representative or his estate must be returned to the Policyholder and/or Us immediately in the event the Policyholder and/or We request the agreement provided for herein and the recipient of such Plan benefits fails or refuses to execute or comply fully with such agreement.
5. This provision shall apply regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not the Eligible Person or the Policyholder is made whole or is fully compensated.

The Eligible Person, by participation in the Policy, agrees that his or her estate, and the legal representative of such estate, shall be obligated to agree that the Policyholder and/or We will have subrogation rights to any recovery or right of recovery the estate has against any third party with respect to the Injury or with respect to any wrongful death claim or action.

REINSTATEMENT OF THIS POLICY

If this Policy is canceled, it may be reinstated only upon written consent from Us on a date determined by Us. Receipt of premium by Us or Our representative does not, in itself, confer reinstatement.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its effective date, is on conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirement of such statutes.