# Occupational Accident Policy

**POLICYHOLDER:** [ABC Employer]

**POLICY NUMBER:** [12356]

**POLICY EFFECTIVE DATE:** [Effective Date]

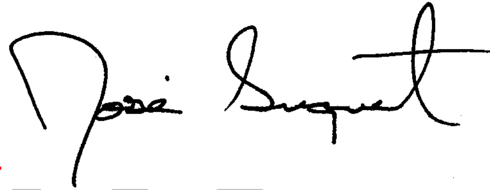
**POLICY TERM:** [Effective Date] to [Expiration Date]

**STATE OF DELIVERY:** Texas

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at end of the Policy Term unless the Policyholder and We agree in writing to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium due date, We will issue a rider to identify the new Policy Term.

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

Signed for Pan-American Life Insurance Company



[ ]

[Chairman of the Board
President and Chief Executive Officer]

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**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE BE AVAILABLE UNDER WORKERS' COMPENSATION LAWS. THE EMPLYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

**THE POLICY CONTAINS A MANDATORY ARBITRATION PROVISION AND IS GOVERNED BY THE FEDERAL ARBITRATION ACT.**

**PLEASE READ THE POLICY CAREFULLY.**

**IMPORTANT NOTICE**

To obtain information or make a complaint:

• You may contact [GreenWood International Insurance Services, Inc. at

1-800-272-7488]

• [You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

**1-800-252-3439**]

• [You may write the Texas Department of Insurance at

P.O. Box 149104
Austin, Texas, 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us]

**PREMIUM OR CLAIM DISPUTES**

[Should you have a dispute concerning your premium or about a claim you should contact the [agent] or TBD first. If the dispute is not resolved, you may contact the Texas Department of Insurance. ]

**ATTACH THIS NOTICE TO YOUR POLICY**

This notice is for information only and does not become a part or condition of the attached document.

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

• [Puede comunicarse con su GreenWood International Insurance Services, Inc. al

1-800-272-7488]

• [Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

**1-800-252-3439**]

• [Puede escribir al Departamento de Seguros de Texas al

P.O. Box 149104
Austin, Texas, 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us]

**DISPUTAS SOBRE PRIMAS O RECLAMOS**

[Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el [agente] o TBD primero. Si no se resuelve la dispula, puede enlonces comunicarse con el departamento (TDI).]

**UNA ESTE AVISO A SU POLIZA**

ESTE AVISO ES SOLO PARA PREPOSITE DE INFORMACION Y NO SE CONVIERTE ON PARTE O CONDICION DEL DOCUMENTO ADJUNT

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## SCHEDULE OF BENEFITS

POLICY NUMBER: [12345]

POLICY HOLDER: [ABC Company]

POLICY TERM: [1/1/2010 – 12/31/2010]

COVERED BUSINESS LOCATIONS: [123 Main Street, Austin, TX 78704]
[additional locations]

**Benefits:**

| | |
|---|---|
| Combined Single Limit (per Plan Participant per Occurrence): | [$100,000 - $5,000,000] |
| Aggregate Limit (per Occurrence): | [$1,000,000 - $10,000,000] |
| Annual Policy Aggregate Limit: | [$1,000,000 - 25,000,000] |
| Accidental Death and Dismemberment Benefit Amount [lesser of: [10] times Base Annual Earnings or: | [$250,000] |
| Deductible [per Plan Participant per Occurrence]: | [$0 - $500,000] |
| Disability Benefit: | [52 - 156 Weeks] |
| Medical/Disability Benefit Period: | [52 - 156 Weeks] |
| Percent of Average Weekly Earnings: | [60 - 75%] |
| Weekly Income Maximum: | [$600] |
| Elimination Period: | [0 - 30 Days] |

**Amendments / Riders:**
**[Amendment/Rider Name]** **[Form Number]**

We will not pay more than the Aggregate Limit for all losses during the Policy Term. If, in the absence of this provision, We would pay more than Aggregate Limit for all losses during the Policy Term, then the benefits payable to each person with a valid claim will be reduced proportionately, so the total amount We will pay is the Aggregate Limit.

Principal Sum is defined as 10x annual base earnings to a maximum of the Combined Single Limit or Accidental Death and Dismemberment or Loss of Use – Principal Sum, whichever is the lesser amount.

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**SCHEDULE OF BENEFITS (Continued)**

**PREMIUM** – Premium adjusted at a rate per Insured

| Class | Class Description | Rate per [Insured] [Payroll] |
|---|---|---|
| [Class Code] | [Class Description] | [Rate] |

Minimum Deposit Premium: [Total Fees]

[Estimated Monthly Premium: [$0.00]]

Estimated Annual Premium: [$0.00]

Payment Mode: [Monthly, Quarterly, Annual]

**Claim Administrator**
[NAME
Telephone: XXXX
Fax: XXXX
Website: www.XXXX.com]

**THE POLICY CONTAINS A MANDATORY ARBITRATION PROVISION AND IS GOVERNED BY THE FEDERAL ARBITRATION ACT.**

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## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**"Accident"** means an external sudden, unexpected and unintended event that occurred during the Policy Period at a specifically identifiable time and place and arose within the Employee's Scope of Employment.

**"Active Service"** means an Insured is either 1) actively at work performing all regular duties on a full-time basis either at his or her employer's place of business or someplace the employer requires him or her to be; or 2) actively at work performing restricted or modified duty work at the direction of the Employer in the course of his or her Scope of Employment; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

**"Appropriate Care"** means the determination of an accurate and medically supported diagnosis and on going medical treatment and care of the Employee's condition or Disability by a Doctor that conforms to generally-accepted medical standards, including frequency of treatment and care.

**"Base Earnings"** means an employee's annual wage or salary as reported by the Policyholder for work performed for the Policyholder as in effect just prior to the date of the Covered Loss. It [does] [does not] include amounts received as bonus, commissions, overtime pay or other extra compensation.

For commissioned employees, Base Earnings shall be the average annual earnings over the then most recent three (3) year period or the period of employment with the Policyholder if shorter, immediately preceding the Occurrence.

For hourly employees, Base Earnings means an employee's earnings as reported by the Policyholder for work performed for the 12 months immediately prior to the date of the Covered Loss. If the employee was not employed by the Policyholder for the full 12 months, Base Earnings means the employee's average monthly earnings from the employer for the months employed times twelve. It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

**"Chiropractic Care"** means chiropractic treatment or therapy provided by a person appropriately licensed to provide chiropractic services, who is not also a member of the Employee's Immediate Family or household.

**"Claims Loss"** means only those [medical benefits, wage replacement benefits, accidental dismemberment benefits and accidental death benefits] actually paid by the Policyholder in accordance with the terms and conditions of the [Plan or Policy].

**"Combined Single Limit Per Occurrence"** is the highest dollar amount We will reimburse for the amounts paid to or on behalf of all Insured's who suffer injuries as a result of any one claim for Claims Losses.

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**"Combined Single Limit Per Insured"** is the highest dollar amount We will reimburse for payments made to any one of the Insureds whether payments or reimbursements are made under one or more of the benefits provided by this Policy for any one claim for Claims Losses.

**"Covered Accident"** means an Accident that occurs during the Policy Term while coverage is in force for an Insured and that results in a loss or Injury covered by the Policy for which benefits are payable.

**"Covered Class"** means a class of Employees defined as eligible under the Policy. Covered Classes are shown in the Schedule of Benefits.

**"Cumulative Trauma"** means damage to the physical structure of the body occurring as the sole result of repetitious, physically traumatic activities that occur solely within the scope of his or her employment. Cumulative Trauma excludes Occupational Injury.

**"Covered Loss" or "Covered Losses"** means an accidental death, dismemberment or other Injury covered under the Policy.

**"Deductible"** means the total amount of Eligible Medical Expenses and Disability expenses incurred for a loss covered under the Accident Medical Expense Benefit and Disability Benefit, as shown on the Schedule of Benefits, that will not be reimbursed under the Policy.

[**"Defense Costs"** is the amount equal to 15% of the Combined Single Limit. Once this Limit is exhausted any amount reimbursed in excess of the Limit on Defense Costs will accumulate to the Combined Single Limit and will be less any reimbursements made for the Insured under the Policy for the same Occurrence.]

**"Disability Benefit Period"** is the maximum period that Disability Benefits may be paid by Us for any one Occupational Injury. It is shown on the Schedule of Benefits

**"Disease"** means a condition marked by a pronounced deviation from the normal healthy state of an Employee that is first diagnosed or treated by a Doctor while the Policy is in force with regard to the person whose sickness is the basis of claim.

**"Doctor"** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to an Insured that is appropriate for the conditions and locality. It will not include an Insured or a member of the Insured's Immediate Family or household.

**"Eligible Medical Expense"** means expenses actually incurred by or on behalf of an Insured for treatment, services and supplies covered by the Policy. An Eligible Medical Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"**Employee"** means a person who, at the time of an Occupational Injury, is employed in the business of, is under the direction and control of, and receives compensation on a regular basis by means of a wage or salary directly from the Employer. Employee includes only those persons who work for the Employer in Texas (or temporarily outside of Texas if at the Employer's direction.)

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[**“ERISA Plan”** or **“Plan”** means the Policyholder’s employee welfare plan to the extent it provides benefits to Employees for covered Occurrences occurring in their Scope of Employment that are subject to the Policy.]

**“Hospital”** means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; 6) is not a place for the care and treatment of mentally ill, emotionally ill ore retarded persons; and 7) is not a place for drug addicts, alcoholics, or the aged.

**“Incurred”** means the date a treatment, service or supply, that gives rise to the expense or the charge, was rendered or obtained.

**“Immediate Family”** means an Insured’s parent, grandparent, spouse, child, brother, sister or in-laws.

**“Injury”** means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

**“Insured”** means a person in a Class of Eligible Employee covered under the Policy and for whom the required premium is paid making insurance in effect for that person.

**“Medical Emergency”** means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

**“Medically Necessary”** means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Insured’s condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

**“Nurse”** means a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN); or, a person licensed in the state in which the nursing or health care service was performed, practicing within the scope of such license.

**“Occupational Disease”** means an unhealthy condition of the body of an Employee diagnosed by a Provider that is generally accepted as a disease or condition of the body caused solely by

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exposure to environmental or physical hazards within the Employee's Scope of Employment, and not caused solely, and independently, by an Accident.

**"Occupational Injury"** means specifically identifiable damages or harm to the physical structure of an Insured's body that is incurred solely as the direct result of an Occupational Accident, and which arose out of the Insured's Scope of Employment. Occupational Injury also includes cumulative trauma or occupational disease only if benefits for cumulative trauma or occupational disease are provided under the [Plan or Policy]. All Occupational Injuries sustained by one Insured in any one Occurrence, including all related conditions and recurrent symptoms of those Occupational Injuries are considered a single Occupational Injury.

**"Occurrence"** means an Accident or series of Accidents arising out of one event or incident occurring during the Policy Term in the Employee's Scope of Employment with the Policyholder that result in his or her Occupational Injury. The date of an Occurrence for an Occupational Injury is the date of an Accident or the date of the first in a series of Accidents. The date of an Occurrence for an Occupational Disease or Cumulative Trauma is the date the condition manifests itself and is diagnosed as an Occupational Disease or Cumulative Trauma.

**"Other Income Benefits"** means any amounts that an Insured or an Insured's dependents receive (or are assumed to receive) under:

1. any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
2. any Social Security or retirement benefits The Insured receive or any third party receives (or is assumed to receive) on Your behalf or for Your dependents; or, if applicable, that Your dependents receive (or are assumed to receive) because of Your entitlement to such benefits.
3. Any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay Our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.

**"Payroll"** for premium calculation purposes means money or substitutes for money paid by the Policyholder to Employees for compensation. For premium calculation purposes, the Payroll for any one Employee in any year is limited to the Payroll Maximum shown on the Schedule of Benefits.

**"Policy Aggregate Limit"** is the most We will pay or reimburse for payments made to, or on behalf of, any or all Insureds for all claims incurred for Claims Losses during the Policy period.

**"Policy Term"** means the period the Policy is in effect. The beginning date is the Policy Effective Date or subsequent Renewal Date and the termination date is the sooner to occur of the cancellation date of the Policy or twelve (12) months after the Policy Effective Date or Renewal Date. Each renewal period begins a new Policy Term.

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**“Pre-Certification”** means the Insured has obtained authorization from the Claims Administrator for non-emergency treatment or services including referral to a specialist prior to incurring Eligible Medical Expenses.

**“Pre-existing Condition”** means – an illness, disease or other condition of the Insured, that in the 12 month period before the Insured’s coverage became effective under the Policy:

1. first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis, care or treatment; or
2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. was treated by a Doctor or treatment had been recommended by a Doctor.

**“Provider”** means any health care provider or Doctor designated by the Policyholder to provide medical treatment for which payment or reimbursement is authorized.

**“Scope of Employment”** means an activity of any kind or character that has to do with and originates in the Policyholder’s work, business, trade or profession, performed by an Employee while engaged in the furtherance of the Policyholder’s business. Scope of Employment does not include an Employee’s transportation to and from his or her place of employment, unless:

1. the transportation is furnished as part of the contract of employment, or is paid for by the Policyholder, or the means of transportation is under the Policyholder’s control; or
2. the Employee is directed in the Scope of Employment to precede form one place to another place.

**“Temporary Disability” or “Temporarily Disabled” or “Disabled” or “Disability”** means an objectively demonstrable physical, anatomical, or physiological abnormality or condition diagnosed by a Provider resulting solely from an Occupational Injury occurring within thirty (30) days of the date of an Occurrence that causes an Employee to be unable to obtain and retain employment at wages equivalent to his or her Base Earnings prior to the Occurrence.

**“Usual, Customary and Reasonable (UCR) Charge”** means the expense is:

1. usual when it is the fee regularly charged, and the patient’s responsibility to pay, in the absence of insurance or other third party reimbursement, by a health care provider or Doctor for a given medical procedure, service or supply; and
2. customary in relation to what other Doctors and health care providers in the same geographic area charge for the same procedure service or supply.
3. reasonable as a generally accepted medical practice to order the procedure, service or supply for the Employee’s Injury or condition.

**“Waiting Period”** means the period of time an Employee who becomes Temporarily Disabled while covered under the Policy must be continuously Disabled before Disability Benefits are payable. The Waiting Period is shown in the Schedule of Benefits and begins on the first day of the Temporary Disability.

**“We”, “Our(s)”, “Us”** refers to the insurance company (the Company) underwriting the Policy.

**“Weekly Wage”** means an Employee’s annual Base Earnings divided by fifty two (52).

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## ELIGIBILITY FOR INSURANCE

Each person in one of the Covered Classes shown in the Schedule of Benefits is eligible. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

## EFFECTIVE DATE OF INSURANCE

An Eligible Person will be insured on the later of Policy Effective Date or the date he or she is eligible, if not required to contribute to the cost of this insurance.

## TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earlier of the date:
1. the Policy Term ends;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid.

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## DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy. All benefits payable under the Policy are subject to and limited by the Deductible and Combined Single Limit shown in the Schedule of Benefits.

### A. ACCIDENTAL DEATH, DISMEMBERMENT OR TOTAL LOSS OF USE BENEFITS

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

| Covered Loss | Benefit Amount |
|---|---|
| Life | 100% of the Principal Sum |
| Two or more Members | 100% of the Principal Sum |
| One Member | 50% of the Principal Sum |
| Thumb and Index Finger of the Same Hand | 25% of the Principal Sum |

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing.

"Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent Loss of Sight of one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "Loss of a Thumb and Index Finger of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). "Severance" means the complete separation and dismemberment of the part from the body.
"Loss of Use" means the total loss of the ability to perform each and every act and service or function that the member was able to perform prior to the Occurrence. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted. It must be beyond remedy by surgical or other means.

### B. ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Eligible Medical Expenses for treatment of an Occupational Injury that results directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductible, Coinsurance Rate, Benefit Period, Combined Single Limit and other terms or limits shown in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual, Customary and Reasonable Charges incurred after the Deductible has been satisfied; and
2. for those Medically Necessary Eligible Medical Expenses for which the Insured receives Pre-Certification; and
3. provided the first Eligible Medical Expense was incurred within thirty (30) days after the date of an Occurrence.
4. No benefits will be paid for any expenses incurred that, in Our judgment, are in excess of Usual, Customary and Reasonable Charges.

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**Eligible Medical Expenses**

1. Medical, surgical, podiatric, optometric, dental, nursing, and physical therapy service provided by or at the direction of a Provider;
2. Chiropractic Care provided it is recommended by a Doctor for the treatment of the Employee's Occupational Injury and services are not rendered by the Provider recommending the treatment.
3. Physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a Provider;
4. Services of a Hospital or skilled nursing facility;
5. Prescription drugs, medicines, and other remedies; and
6. Medical and surgical supplies, appliances, braces, artificial members, and prostheses, including training in their use.

Benefits will be payable at a different Co-insurance Rate for Preferred Providers than Non-Preferred Providers as shown in the Schedule of Benefits. The rate will not be less than 80% for a Non-preferred Provider nor more the 100% for a preferred Provider.

Benefits will be payable at the Preferred Provider rate when the Insured receives services from a Non-preferred Provider that are; a) not available through a Preferred Provider; or b) for a Medical Emergency and the Insured cannot reasonably reach a Preferred Provider. We will continue to pay benefits at the higher rate for a Medical Emergency until the time the Insured can reasonably be expected to safely transfer care to a Preferred Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the rate for a Non-preferred Provider.

"Non-Preferred Provider" means a licensed provider of medical services who is not under agreement with the Administrator to provide those services. "Preferred Provider" means a licensed provider of medical services who is under agreement with the Administrator to provide those services.

## C. DISABILITY BENEFITS

We will pay the Disability Benefit shown in the Schedule of Benefits if an Insured is Temporarily Disabled by an Occupational Injury that is a direct result of, and from no other cause but, a Covered Accident. Disability Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Insured provides satisfactory proof of Temporary Disability to Us, provided the Insured is:
3. under the Appropriate Care of a Doctor; and
4. the Temporary Disability begins within thirty (30) days after the date of an Occurrence.

Disability Benefits are payable on a weekly basis at the lesser of the Percentage of Average Weekly Earnings or the Maximum Weekly Benefit shown in the Schedule of Benefits subject to the Deductible and Combined Single Limit.

If the Insured is employed at less than his or her Average Weekly Earnings while he or she remains partially Disabled, the Disability Benefit payable will be reduced by the Insured's taxable earnings during the period.

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Benefits will not be paid if the Insured refuses to participate in any medically recommended rehabilitation program or if the Disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Insured has not availed himself or herself of the treatment.

Otherwise, Disability Benefits will end on the first of the following dates:

1. the date the Insured dies; or
2. the date the Insured is no longer Temporarily Disabled; or
3. the date the Disability Benefit Period shown in the Schedule of Benefits ends; or
4. the date the Insured fails to submit satisfactory proof of continuing Disability.

Benefits will not be payable under the Policy for successive periods of Disability that result from entirely different and unrelated causes unless such periods of Disability are separated by at least one full day during which the Insured is not Disabled and returns to Active Service.

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## SCOPE OF COVERAGE

**AGGREGATE LIMIT.** All payments under the Policy will reduce the Aggregate Limit by the amount paid. Our obligation to pay benefits under the Policy shall be limited to the Aggregate Limit, as so reduced, for all Occurrences during the Policy Term.

**OTHER INSURANCE.** If the Insured is protected against any loss covered by the Policy by an other insurance, indemnity, or reimbursement contract, the Policy shall apply only in excess of the other contract of insurance, indemnity or reimbursement.

**DEDUCTIBLE.** We will pay benefits only for the amount in excess of the Deductible and up to the limits stated in the Schedule of Benefits. In no event will We be required to pay benefits below the Deductible. We shall have no obligation to reimburse any sum under the Policy until the Deductible.

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## EXCLUSIONS

We will not pay benefits for any loss or Occupational Injury that is caused by, or results from:

1. intentionally self-inflicted injury; suicide or attempted suicide.
2. war or any act of war, whether declared or not, or participation in a riot or act of civil disturbance.
3. service in the military, naval or air service of any country or any civil non0combatabt unit serving with such forces.
4. sickness, disease, or any ptomaine or bacterial infection except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. violation or attempt to violate any duly-enacted law, or the commission or attempt to commit an assault or a felony, or a loss that occurs while the Insured is engaged in an illegal occupation or activity.
7. alcoholism, drug addiction, intoxication or the use of any drug or narcotic except as prescribed by a Doctor.
8. use of, or exposure to asbestos, asbestos fibers or asbestos products, the hazardous properties of nuclear material, silicon, silicate dust or silicosis.

Nor will We pay benefits for, or related to:

1. claims made by an Insured due to an Occurrence, except as provided under the Policy.
2. actual or punitive damages for Injury to an Insured while employed in violation of the law.
3. liability to any third person due to an Occurrence.
4. liability assumed by the Policyholder under any contract agreement, including representations, warranties or indemnities of any kind.
5. liability for breach of legal employment relationships including, without limitation, claims for discrimination, wrongful discharge, retaliatory discharge, coercion, sexual and/or racial harassment, Americans with Disabilities Act claims, Age Discrimination in Employment Act claims, Pregnancy Discrimination Act claims, Railway Labor Act claims, Texas Human Rights Act claims, Worker Adjustment and Retraining Notification claims, wrongful discharge claims, “whistleblower” claims, and all other matters affecting or arising from the employment relationship.
6. liability under the Federal Employers Liability Act, the Longshore and Harbor Workers’ Compensation Act, the Jones Act, or the Migrant Seasonal Agricultural Worker Protection Act.
7. fines, assessments or penalties, whether arising under federal, state or local ordinance.
8. liability due to all statutory causes of action, including, without limitation: Title VII of Civil Rights Act of 1964; Civil Rights Act of 1991; Civil Rights Act of 1866; Age Discrimination in Employment Act; Insured Retirement Income Security Act; Fair Labor Standards Act; Bankruptcy Code; Texas Commission on Human Rights Act; Texas Workers’ Compensation Act; Railway Labor Act; and National Labor Relations Act.
9. liability for:
   a. claims under any contract of employment, whether written, oral, or implied;
   b. a breach of duty of good faith and fair dealing;
   c. breach of non-competition agreements;
   d. claims for tortious interference with contractual relations;
   e. intentional or negligent infliction of emotional distress; or
   f. claims against the Insured based on assault and battery, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation and

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fraud, false imprisonment, false arrest, malicious prosecution, and unreasonable search.

In addition to the exclusions above, We will not pay Accident Medical Expense Benefits or Disability Benefits for:

1. Pre-Existing Conditions.
2. Treatment by persons employed or retained by a Policyholder, or by any Immediate Family or member of the Insured's household.
3. Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, stoke, heart attack, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an Occupational Injury, or mental or nervous disorder or psychological or psychiatric care or treatment, whether or not caused by a Covered Accident.
4. Cumulative Trauma or osteoarthritis, arthritis, and/or any degenerative process of the joints, bones, tendons or ligaments.
5. Injury covered by any state Workers' Compensation, Occupational Disease, Employer's Liability Laws, unemployment compensation, disability law or other similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
6. Eligible Medical Expenses for which the Insured would not be responsible for in the absence of the Policy.
7. Conditions that are not caused by a Covered Accident or any diagnostic procedure, treatment, service or supply that is not Medically Necessary or Pre-Certified in advance.
8. Participation in any activity or hazard not specifically within the Insured's Scope of Employment.
9. Occupational Disease.

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## ADMINISTRATIVE PROVISIONS

**Premium.** Premium shall be paid in monthly, quarterly, semiannual, or annual installments, as shown on the Schedule of Benefits, with a minimum and deposit premium due with the Policyholder's Application. We have the right, during the Policy Term and for a period of three years thereafter, to audit the Policyholder's Payroll and assess and review the Policyholder's records to determine the correct amount of Premium due under the Policy.

The amount of each premium payment is the sum of the products of:

1. the Payroll of all Employees within each of the occupational class code(s) at the beginning of each reporting term during the Policy Term; and
2. the premium rate for the respective occupational class code(s) as determined by Us at the beginning of the Policy Term.

**Changes In Premium Rates:** We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**Cancellation.** The Policyholder may cancel the Policy at any time with 31 days written notice to Us. We may cancel the Policy at any time for the following reasons:

1. Policyholder fraud in obtaining this coverage;
2. failure to pay any Premium or other sum under the Policy when due;
3. an increase in workplace hazards within the Policyholder's control, that would produce an increase in premium rate;
4. loss or change of the reinsurance covering all or part of the risk covered by the Policy; or
5. if We are placed in supervision, conservatorship, or receivership, if the cancellation is approved or directed by the supervisor, conservator or receiver.

We may cancel the Policy by delivering or mailing to the Policyholder, by registered, certified, or first class mail, at its last known address, written notice of cancellation stating the reason for cancellation and stating when, not less than 30 days thereafter, the cancellation shall be effective, except for non-payment of any installment or additional amount of Premium. If the Policyholder fails to pay any Premium when due, the written notice shall state a date when the cancellation is effective.

If the period of limitation relating to the giving of notice is prohibited or made void by any controlling law, such period will be deemed amended so as to be equal to the minimum period of limitation permitted by such law. If the Policy is canceled by the Policyholder, We will retain the pro rata portion of the Premium and/or the minimum and deposit premium, whichever is larger.

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If the Policy is canceled We will retain the pro-rata proportion of the Premium determined by the Premium Percentage of Payroll. A statement of actual Premium due will be rendered after the Policy expiration date, and if the Premium earned is greater or less than the Premium actually paid for the Policy Term, then such additional, or returned, Premium will be due and payable within 30 days.

We may refuse to renew the Policy by delivering or mailing to the Policyholder, by registered, certified, or first class mail, at its last known address, not less than 30 days prior to the expiration date of the Policy, written notice of non-renewal, stating the reason for non-renewal. Coverage will remain in effect until the 31st day after the date on which the notice is delivered or mailed.

**Policy Grace Period:** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**Access To Books And Records.** The Policyholder's books and records, and those books and records of any agents and representatives, any loss control or risk management, and third party administrator, shall be open for inspection by Us and Our representatives at all times during usual business hours during the Policy Term and for three years thereafter. We or Our representatives may audit any and all such books and records, and make and take away copies thereof, relating to the Policy, claims hereunder, Payroll and Premium.

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## CLAIMS ADMINISTRATION

**Claim Handling.** We, or a claims administrator appointed by Us, will, subject to the conditions contained herein, investigate and adjust any claim under the Policy made against the Policyholder arising from any Occurrence. The Policyholder shall cooperate fully and, upon request, supply such information as may be required in order to adjust the claim. The Policyholder's failure to exercise diligence, prudence and good faith, or its willful mishandling or mis-administration of any claim may result in forfeiture of coverage for the claim.

No investigator, adjuster, or counsel shall be employed to represent Our interest without Our prior written approval. We reserve the right to obtain other professional services at Our expense, as We deem necessary. The Policyholder shall not make any payment nor incur any obligation to pay any sum other than pursuant to the terms of the Policy.

**Medical Cost Review Requirement.** As a condition precedent to payment of claims under the Policy, the Policyholder agrees to implement, and the Employee and the Policyholder agree to follow, medical care cost containment procedures as may be recommended by a third party medical cost containment service selected by Us.

**Physical Examination and Autopsy.** We, at Our own expense, have the right to have an Insured examined when and as often as reasonably necessary while a claim is pending. Failure to submit to the examination will result in termination of coverage relating to the Insured. We also can have an autopsy performed, at Our expense, unless prohibited by law.

**Commutation Clause.** All claims under the Policy, if any, may at Our option, be commuted [36 months] after the end of the Policy Term. The Policyholder will submit a list of all claims under the Policy 30 days prior to the commutation date. The claim listing the Policyholder provides must include all pertinent information necessary to arrive at valuation of all claims. The claim listing the Policyholder supplies will be submitted to an actuary or appraiser mutually acceptable to both the Policyholder and the Company to determine the discounted net worth of all claims. We will pay the Policyholder the discounted net worth of each claim that is in excess of the Deductible, subject to the Combined Single Limit, within 30 days of receipt from the actuary or appraiser. Payment to the Policyholder in accordance with this paragraph will achieve a complete settlement and discharge of all present or future, known or unknown, claims under the Policy.

If the actuary or appraiser cannot be agreed upon by both the Policyholder and Us, each will appoint its own actuary or appraiser who will, in turn, appoint an independent actuary or appraiser who will establish the discounted net worth of each claim. We will pay the Policyholder the discounted net worth of each claim that is in excess of the Deductible, subject to the Combined Single Limit, within 30 days of receipt from the independent actuary or appraiser.

**Assignment.** The Policy is not assignable unless We consent in writing to its assignment. An interest in death benefits is assignable but no assignment of death benefits is effective until an original assignment and any other requested documents are received by Us. We assume no responsibility for the validity of any such assignment.

**Claimant Cooperation Provision:** Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether

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benefits are payable or the actual benefit amount due.

**Payment Of Claims:** If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary our records indicate the Insured designated for these plan benefits. If no named beneficiary or surviving beneficiary is on record with Us or Our authorized agent, death proceeds will be paid to the beneficiary the Insured has designated under the Group Life Insurance Policy issued to the Policyholder and in effect at the time of the Insured's death.

If there is no named beneficiary or surviving beneficiary on record under the Group Life Insurance Policy issued to the Policyholder or with us or Our authorized agent, We pay benefits in equal shares to the first surviving class of the following:

1. Spouse;
2. Children;
3. Parents;
4. Brothers and sisters

If there are no survivors in any of these classes, We will pay the Insured's estate.

All other benefits will be paid to the Insured. If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.

**Beneficiary:** The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. A beneficiary has no interest in the policy other than to receive the benefits for loss of life. The Insured may change the beneficiary at any time unless his or her interest has been assigned. Unless there has been an assignment, consent to change by a prior beneficiary is not needed.

The name of the beneficiary is not effective until entered on the records of the Policyholder. We are not responsible for the correctness of the records.

If the Covered Person is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Insured is the beneficiary for any covered Dependent.

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## NOTICE OF CLAIM AND LOSS REPORTS

The Policyholder agrees to give written notice to Us, or as directed by Us, as soon as reasonably practicable, of each Occurrence that may give rise to a claim under the Policy and of each subsequent development that is related to the claim.

Written notice of claim must be given to Us within 30 days after the date of the Occurrence immediately for any Occurrence involving any of the following:

1. disability for a period of seven days or more;
2. spinal cord Injury;
3. severe burn Injury;
4. brain Injury;
5. Injury of two or more Insureds from a single Accident;
6. death of an Insured;
7. any suit claiming damages involving an Occurrence;
8. multiple trauma;
9. motor vehicle Accident.

Notice given to Us or to any authorized agent of Ours, with information sufficient to identify the Policyholder and the Insured(s), and contained on forms supplied by Us, shall be deemed notice to Us.

The Policyholder will give immediate notice to Us, including copies, upon receipt, of each lawsuit served or written demand made upon the Policyholder by any Insured or any attorney representing an Insured, irrespective of the amount claimed.

Within fifteen (15) days after receipt of written notice of claim from the Policyholder, We will furnish claim forms to, and request from the Policyholder, all items, statements, and forms that We reasonably believe, at that time, will be required from the Policyholder. Additional requests may be made during the investigation of the claim. If claim forms are not furnished, the Policyholder will be considered to have met the requirements for written proof of loss if the Policyholder delivers written proof of the loss to Us, including a description of the Occurrence, and the extent, date, and nature of the loss.

Written proof of loss must be delivered to Us within 30 days after the date of such loss. If it is not reasonably possible to deliver the proof within 30 days, the claim is not affected if the proof is delivered to Us as soon as possible; however, such proof must be delivered within 365 days of the date of loss.

**Settlement.** The Policyholder agrees not to make any voluntary settlements involving payments by Us. We have all rights to adjust and settle claims for benefits under the Policy in excess of the Deductible. If the Policyholder refuses to consent to any claims settlement demanded by the claimant and recommended by Us (the "claims settlement amount"), but instead elects to contest a claim or to continue litigation at the trial level or at the appellate level in connection with such claim, then Our obligation under the Policy for such claim will not exceed the difference between the Deductible and the lesser of the claims settlement amount or the remaining Combined Single Limit. We may discharge all obligation under the Policy on account of any such claim or suit by paying the difference between the Deductible and the lesser of the claims settlement amount or the remaining Combined Single Limit. The Policyholder releases Us from any further liability for such claim upon Our payment as outlined above.

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**Subrogation.** If payment is made under the Policy, We will be subrogated to all of the Insured's rights of recovery, and all such rights of any person receiving monies provided or paid by the Policy, against any person or organization except the Policyholder and its affiliates, and the Insured agrees to execute and deliver instruments and do whatever else is necessary to secure Our subrogation rights. Neither the Policyholder or the Insured will do nothing to prejudice Our subrogation rights, without Our prior written consent.

**Sunset Clause.** We will cover claims based upon Occurrences described in the Policy occurring during the Policy Term provided that, and only in so far as, such claims and Occurrences are reported to Us within [36 months] after expiration of the Policy Term. Claims reported to Us after such date are not eligible for payment under the Policy.

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## GENERAL PROVISIONS

**Policyholder Not Company's Agent.** The Policyholder shall in no event be considered Our agent for purposes of the Policy or any other purpose.

**Inspection And Safety.** For Our sole and exclusive benefit, an underwriting inspection by Our designated safety engineer, or safety inspector, will be permitted at all of the Policyholder's workplace(s), with or without notice, during the Policyholder's regular business hours.

As a condition precedent to the Policyholder's right to payments on behalf of an Employee under the Policy, the Policyholder warrants that it will keep in place the safety procedures and/or loss control engineering services and/or safety consultants and/or claims administration procedures and/or claims consultants and/or third party administrators that it disclosed to Us on its Application, when and where requested. Notice of any proposed amendment to the specific procedures, personnel, and/or services must be provided to Us. The Policyholder agrees that We have the right to inspect, through Our authorized representatives, at any reasonable time, its books, records and premises to verify that it has kept these procedures, personnel, and/or services in place, as represented.

**Action Against Us.** No action by the Policyholder will lie against Us unless, as a condition precedent thereto, it has fully complied with all the terms of the Policy, and until the amount of any obligation to pay damages arising from any Occurrence shall have been finally determined either by judgment against the Policyholder after actual trial or by written arms-length agreement between the Policyholder and the Employee claimant, and only after payment has been made by the Policyholder in full satisfaction of all expenses in connection with the Occurrence. Nothing contained in the Policy shall give any person or organization any right to join Us as a co-defendant in any action against the Policyholder to determine the Policyholder's liability for any Occurrence.

**Binding Arbitration.** In the event of any dispute, controversy or claim between the parties to the Policy, including their officers, directors, employees, owners, heirs, assigns, affiliates, reinsurers, or agents, related to or arising out of the matters covered by this agreement or its breach, such dispute, controversy, or claim will be finally settled by binding arbitration pursuant to the procedures set forth in this arbitration provision. The scope of this arbitration provision includes but is not limited to performance of the respective obligations of the parties under the Policy, any questions of interpretation of any article, clause, or other provision of the Policy, any claim for breach of the duty of good faith and fair dealing, breach of contract, or any claim for violation of any state, federal, or governmental law, statute, regulation or ordinance including, but not limited to, the Texas Deceptive Trade Practices Act and the Texas Insurance Code. The parties agree that the insurance provided by the Policy involves commerce among multiple states, and therefore the Federal Arbitration Act and related federal procedure will govern arbitration as set forth in this provision to the fullest extent possible and state arbitration law will not apply.

This arbitration will be governed by the Commercial Arbitration Rules of the American Arbitration Association unless specifically varied by the terms stated in this arbitration provision. Either party may make a written demand for arbitration, setting forth the nature of the dispute and naming an arbitrator with a minimum of 10 years' experience in the insurance industry, by registered or certified mail, return receipt requested. Notice to the Policyholder will be sent to the address furnished by the Policyholder in its application for coverage, unless We have

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received written notice of an address change from the Policyholder. Notice to Us will be sent to Us at the Company address.

When a demand is made, the noticed party will have 30 days to respond and name a second arbitrator. If the noticed party does not respond by naming a second arbitrator within 30 days, the arbitrator named by the demanding party will be the sole arbitrator to hear the dispute. If the remaining party responds within the 30 days by naming a second arbitrator, the two arbitrators will select a third arbitrator with a minimum of ten years' experience in the insurance industry. Each party will pay the cost of its own arbitrator if a panel is selected consisting of two party arbitrators and an umpire. If the two arbitrators cannot agree upon a third arbitrator within 30 days, either may request that the selection of the third arbitrator be made by the Dallas, Texas office of the American Arbitration Association. A decision agreed to by two arbitrators will be binding.

The parties agree that the Policy is to be performed in Dallas, Texas. Unless both parties agree otherwise, arbitration will take place in Dallas, Texas. Arbitration will be conducted by written submission unless either party requests a live hearing before the arbitrator(s) at least 10 days prior to the due date for the written submission. Discovery will be limited to the exchange of documents. If there is to be a hearing, each side additionally will submit to the panel and the other party a detailed position brief, one week prior to the hearing, to include disclosure of witnesses to be called at the hearing. Affidavits of witnesses not testifying at a hearing will not be admitted.

The arbitrator(s) will not be bound by federal, state, or local rules of evidence or procedure, other than as set forth by the Federal Arbitration Act, and will apply the substantive law of the State of Texas or the industry standard or practice relating to the issue under consideration. Failure to correctly apply Texas substantive law because industry standard or practice was applied in lieu thereof, will neither void the arbitration award nor provide grounds to appeal to a court to vacate the award. The arbitrator(s) will deliver a decision stating only the arbitrators' ultimate determination within 30 days after a hearing on the issues or the written submission, and payment of any amounts awarded to either party will be due within 30 days after the issuance of the award, after that time interest on the award will accrue from the date the award was issued at a rate of 12% per annum until the award is finally paid. Any decision or award resulting from any arbitration proceeding will include assessment of costs, expenses and reasonable attorneys' fees. Judgment on the award rendered by the arbitrators, including any post-award interest, may be entered in any Court having jurisdiction thereof, and any costs of obtaining or collecting on the judgment, including reasonable attorneys' fees, will be assessed against the party against whom the judgment is filed and granted. Arbitrators will be limited to the award of actual or compensatory damages and costs only (including consequential damages), and will not be permitted to award punitive or exemplary damages against either party.

This arbitration provision will not be construed to deny any court having jurisdiction the power to award, in appropriate circumstance, interim relief pending arbitration, including, but not limited to, temporary restraining orders and injunctions, provided that it is not feasible for the arbitrators to consider such relief rapidly enough to prevent serious harm to the party seeking the relief and, provided further, that the arbitrators have not already considered such relief and refused to allow it. Notwithstanding the need for interim relief, if any party to the Policy pursues a claim covered by this arbitration provision by litigation rather than arbitration, the responding party will be entitled to the dismissal of such action along with the recovery of all cost, attorneys' fees, and actual losses directly related to such action.

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This arbitration clause will survive the expiration or other termination of the Policy.

**Clerical Error.** If a clerical error is made, it will not affect the insurance of any Insured. No error will continue the insurance of an Insured beyond the date it should end under the Policy terms.

**Not In Lieu Of Workers' Compensation**: The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

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## ACCEPTANCE OF POLICY

The Application, the Policy form, the Schedule of Benefits, notice pages, and all Endorsements form the terms, conditions, exclusions, representations, and warranties of the Policy.

By accepting the Policy, the Policyholder agrees that the statements in the Application and the Schedule of Benefits are the Policyholder's own representations; that the Policy is issued in reliance upon these representations; that the Policy embodies all agreements existing between the Policyholder and Us or any of Our agents, relating to this insurance, and that full compliance by the Policyholder with all terms of the Policy is a condition precedent to Our obligation to pay benefits under the Policy.

No change in the Policy is valid unless approved in writing by Us. Only Our President, Vice President, or Secretary may agree to alter the Policy and only by rider, endorsement or amendment in writing. No agent has the authority to change the Policy or to waive any of its provisions.

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