VFIS®
A Division of Glatfelter Insurance Group®
A Tradition of Service, Founded on Trust.

Thank you for selecting the VFIS Accident and Sickness Program. As you know this coverage is intended to provide financial security to your members and their families in the event of an injury or illness occurring while performing duties as a member of your organization.

It's unfortunate that every year well over 100,000 emergency service personnel suffer disabling injuries. The financial and emotional hardship associated with these injuries is well documented. We at VFIS are committed to identifying patterns associated with the injuries. Once identified, we develop and offer programs which could help reduce the frequency and severity of these incidents.

We are pleased to announce the availability of a program assigned to identify some of the more common situations relative to health and safety. The material is divided into three parts. First, we identify and explain these situations. Second, we offer a summary of key areas for your review, and finally, we illustrate VFIS programs which could help address these specific health and safety issues.

As a VFIS Accident and Sickness insured, the majority of these programs are available to you organization at no charge. If you are interested in obtaining any of these programs simply call, email, or visit our web site www.VFIS.com.

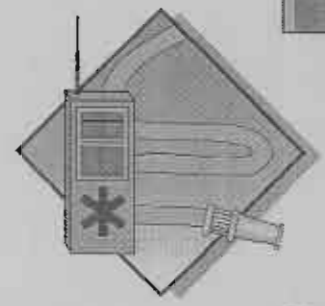
Keeping your emergency service personnel safe and injury free should be our mutual goal. We believe using these programs will be a positive step. Should you require any additional information or if you have a recommendation for additional programs please call your insurance agent or VFIS Risk Control Services at 1-800-233-1957.

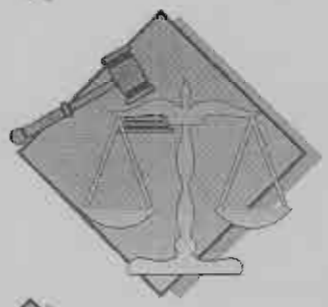
Sincerely,

David Wyrwas, CLU, ChFC, CIC
President VFIS

Todd W. Thompson, ALCM, MSS
Senior Vice President Risk Control Services

183 Leader Heights Road • P.O. Box 2726 • York, Pennsylvania 17405
(717) 741-0911 • (800) 233-1957 • Fax (717) 747-7020 • www.vfis.com





VFIS®

A Division of Glatfelter Insurance Group

Accident & Sickness Claim Service Guide for Insureds and Agents

This guide references policies that are underwritten by American Alternative Insurance Corporation (AAIC) and National Union Fire Insurance Company of Pittsburgh, PA, an AIG Company.

AIG

AAIC
American Alternative Insurance Corporation

A01:111AS (5/04)

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

DATE OF THIS REPORT_____

TO BE COMPLETED BY INJURED PERSON

Home Telephone No. (AC)_____
Work Telephone No. (AC)_____
Name_____ Soc. Sec. No._____

Home Address_____ City_____ State_____ Zip_____

Date of Accident or Organization's Activity_____ Year: _____ Occurred_____ am pm
Date of Birth_____ Sex_____ Weight_____ Height_____ Marital Status_____
Full-Time/Regular Occupation_____ Income: Weekly_____ Yearly_____
Name and address of full-time employer_____

Employer Telephone No.:_____ Length of employment in this work:_____

Please completely answer the next three questions:

1. What activity were you involved in when injured or became ill?

2. How did accident or sickness occur?

3. What is your injury or sickness?

Give date of first day of full-time occupation missed due to above accident and sickness _____
Give date you were able to return to work _____
Attending Physician's Name, Address and Telephone Number _____

Name and Address of Hospital _____ Dates Hospitalized
From _____ _____ Year
To _____ _____ Year

AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish VFIS, Inc. with information they may request regarding details of my past medical history and physical condition. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin _____ Relationship _____ Date _____

TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
- If claimant is a member of organization, please circle type of member: junior adult auxiliary (Circle one)
- Was the injured person engaged in an authorized activity of your organization at the time of injury or commencement of sickness? Yes No
- Name and Address of Insured Organization
- Policy Number_____
- Organization Telephone Number_____
- Home Telephone Number of Official Signing Below_____

I certify that the above is true.

- Signed _____ • Title _____ • Date _____

Applicable in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in California

For your protection, California law requires the following to appear in this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in all other states

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

ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

VFIS
P O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax # (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

Name of Patient _____ Age _____

Address _____ Telephone _____

Regular Occupation _____

Name of Insured Organization _____ Policy No. _____

IMPORTANT

Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature _____
Insured Member Patient

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

Dear Doctor:

The above named individual has filed a claim for benefits as a result of the Accident/Sickness for which he is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. ***The Company does not assume any expense incidental to the completion of this form.***

(1) Diagnosis and Concurrent Conditions
(If Fracture or Dislocation, Describe Nature and Location,
If Sickness Describe Nature)

(2A) When Did Symptoms First Appear or Accident Happen? Date _____ _____ Year

(B) When Did Patient Consult You For This Condition? Date _____ _____ Year

(C) Has Patient Ever Had Same or Similar Condition?
(If Yes, State When and Describe) Yes _____ No _____

(3A) Nature of Surgical Procedure, If Any (Describe Fully) - Date Performed _____ _____ Year

(B) If Performed in Hospital, Give Name and Address - Inpatient _____ Outpatient _____

(4) What other Services, If Any. Did You Provide Patient?

(5) Is Patient Still Under Your Care For This Condition? Yes _____ No _____
If "No" Give Date Your Services Terminated. Date _____ _____ Year

(6A) How Long Was or Will Patient Be Continuously Totally Disabled (Unable To perform Regular Occupation) Due to Diagnosis in #1 Above? From _____ _____ Year Thru _____ _____ Year

(B) How Long Was or Will Patient Be Partially Disabled? From _____ _____ Year Thru _____ _____ Year

(C) Approximate Date Patient Will Return To Work If Still Disabled. _____ _____ Year

Date Signature

(attending physician) (degree) (telephone no.)

Street Address City or Town State or Providence Zip Code

Applicable in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in California

For your protection, California law requires the following to appear in this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in all other states

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

VFIS
A Division of Glatfelter Insurance Group
A Tradition of Service, Founded on Trust.

TO: All Accident & Sickness Policyholders

From: VFIS

Re: Beneficiary Forms

It is very important to review the designated Beneficiary Forms that you have on file on a regular basis to insure that they are current and correct. Marriages, Divorces and Deaths can affect Beneficiary selections and a periodic review, at least every few years, is very important.

For this reason we are attaching a small supply of Beneficiary Forms and requesting that you review the beneficiary selections with your covered individuals and use these forms to update any current records that are outdated. **The completed forms should be kept on file at your department,** so that if Beneficiary changes are necessary, the forms are readily available.

It is very important that everyone completes a Beneficiary Form to insure that their benefits will be paid to the individual(s) of their choice. In the event there is no Beneficiary on file, the policy will automatically pay benefits to the first surviving class as follows:

1. Spouse
2. Children
3. Parents
4. Brothers or sisters

If none of the above exists, the benefits will be paid to the estate.

Please make sure your Beneficiary cards are current before it is too late. If you have any questions or need additional cards, please contact your agent.

Attach

183 Leader Heights Road • P.O. Box 2726 • York, Pennsylvania 17405
(717) 741-0911 • (800) 233-1957 • Fax (717) 747-7020 • www.vfis.com

VFIS

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

Contingent
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature_____ **Date** _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

C01:008A (11/05)

VFIS

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

Contingent
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature_____ **Date** _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

C01:008A (11/05)

Specifying Beneficiaries

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies), who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

Specifying Beneficiaries

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

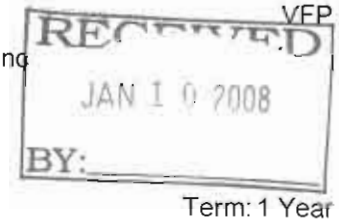
** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

SCHEDULE OF COVERAGE

Policyholder: VFIS TRUST

Policy Number: VFP 2347-7994C-04

Participating Organization:
Appalachian Search and Rescue Conference, Inc
1213 Prince Street
Alexandria, VA 22314



Policy Effective Date: 02/01/2008

Term: 1 Year

Policy Expiration Date: 02/01/2009

Premium: $ 2,542

This summary of coverage provides only those following benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by the word "none" are not provided.

PART	COVERAGE	AMOUNT OF INSURANCE
I.	**Loss of Life Benefits**	
	A. Accidental Death Benefits	
	(i) Accidental Death Indemnity Benefit	$ 10,000
	(ii) Seat Belt Benefit Amount	$ 5,000
	B. Illness Loss of Life Benefit	$ 10,000
	C. Dependent Benefit Amount (Per Dependent Child)	$ 10,000
	D. Spousal Support Benefit Amount	$ 5,000
	E. Memorial Benefit Amount	$ 2,000
II.	**Lump Sum Living Benefits**	
	A. Accidental Dismemberment Principle Sum	$ 10,000
	B. Vision Impairment Benefit	$ 10,000
	C. Optional Permanent Physical Impairment Principle Sum - Injury Only	$ 10,000
	D. Cosmetic Disfigurement Resulting From Burns Principle Sum	$ 10,000
	E. HIV Positive Benefit	$ 10,000
III.	**Weekly Income Benefits**	
	A. Total Disability Benefit	
	(1) Total Disability Weekly Income Benefit (first 28 Days)	$ 100
	(2) Total Disability Maximum Weekly Amount (after 28 Days)	$ 100
	(3) Total Disability Minimum Weekly Amount	$ 25
	B. Partial Disability Benefit	
	(1) Partial Disability Weekly Income Benefit (first 28 Days)	$ 50
	(2) Partial Disability Maximum Weekly Amount (after 28 Days)	$ 50
	(3) Partial Disability Minimum Weekly Amount	$ 13
IV.	**Occupational Retraining Benefit Maximum Amount**	$ 20,000
V.	**Weekly Permanent Physical Impairment Benefit**	$
VI.	**Optional Weekly Permanent Physical Impairment COLA Benefit**	☐ Yes ☒ No
VII.	**Medical Expense Benefits**	
	A. Medical Expense Maximum Amount	$ 10,000
	Medical Expense Benefit Options	
	1. Excess of Workers' Compensation or No-Fault Auto Insurance Benefits	☐
	2. Excess of Workers' Compensation, No-Fault Auto Insurance and Other Group Insurance	☐
	3. Primary Medical Expense Benefit	☒
	B. Cosmetic/Plastic Surgery Maximum Amount	$ 10,000
	C. Post Traumatic Stress Disorder Maximum Amount	$ 10,000
	D. Critical Incident Stress Management Maximum Amount Per Covered Activity	$ 2,500
	E. Family Expense Benefit	$ 100
VIII.	**Optional Benefits**	
	A. Weekly Hospital Indemnity Benefit	$ none
	B. Additional Disability Weekly Benefit	$ none
	C. 24 Hour Accidental Death and Dismemberment Benefit	$ none
	D. Non-Covered Activity Accidental Death and Dismemberment Benefit	$ none

Additional Participating Organizations/Policyholders:

Alleghany Mountain Rescue
Blue Ridge Mountain Rescue
Maryland Search & Rescue
Mountaineer Area Rescue
Piedmont Search & Rescue
Potomac Valley Search & Rescue
Shenandoah Mountain Rescue
Southwest Virginia Mountain Rescue
Tidewater Search and Rescue

Policy Forms Attached at Issuance:

V30028-2005	Summary of Coverage - Volunteer - 2005 Version
V30388	Amendatory Endorsement - 2005
V30380-T	Felonious Assault Benefit Rider
V30381-T	Home Alteration and Vehicle Modification Rider

NATIONAL UNION
FIRE INSURANCE COMPANY
OF PITTSBURGH, PA.
A CAPITAL STOCK COMPANY

Home Offices: Pittsburgh, PA 15222
Executive Offices: 70 Pine Street, New York, NY 10270
212/770-7000

AMENDATORY ENDORSEMENT

In consideration of the payment or premium calculated in the manner stated in the summary of coverage to which this endorsement is attached, it is hereby agree that the summary of coverage is ammended as follows:

I. The section entitled **Schedule of Coverages**, appearing in the policy is deleted and replaced with the attached **Schedule of Coverages.**

II. The definition of **Insured Person**, appearing in the section entitled **"GENERAL SUMMARY OF COVERAGE DEFINITIONS"**, is deleted and replaced by the following.

Insured Person - means any officially designated member of a **Participating Organization** while acting as: (1) a volunteer member for the **Participating Organization**; (2) any junior member or member in training; (3) any commissioner, director, trustee or other similar position associated with the **Participating Organization**; (4) any bystander deputized at the time of the emergency by an official of the **Participating Organization** to assist in an emergency, but only during the actual emergency; (5) an auxiliary member; (6) any non-member who is requested to participate by the auxiliary or **Participating Organization**; and (7) any member who receives remuneration for "on call" duty or out of pocket expenses subject to the following:

An **Insured Person** will not include a member who looks to the **Participating Organization** for their primary source of income while acting within the scope of their employment unless the policy is specifically endorsed to provide coverage for career members. A member will be deemed to look to the **Participating Organization** for their primary source of income if they: (1) average 25 hours or more employment per week; or (2) are salaried and work a schedule of more then 25 hours per week. The time frame used to determine the average hours or the salaried schedule will be the same time frame used to calculate the **Average Weekly Wage** in **Part III.** of the policy.

III. The section entitled **"B. ILLNESS LOSS OF LIFE BENEFIT"**, appearing under **PART I.**, is deleted and replaced by the following.

B. ILLNESS LOSS OF LIFE BENEFIT

We will pay the **Illness Loss of Life Benefit** shown in the **Schedule** if death to an **Insured Person**: (1) occurs during a specific **Covered Activity** and is not otherwise payable as an **Accidental Death Indemnity Benefit**; or (2) occurs due to an **Illness** covered as a result of participation in a specific **Covered Activity**. Either: (1) death; or (2) medical treatment for the **Illness,** must occur within 48 hours of the **Covered Activity.** The requirement that death occurs, or medical treatment for the **Illness** be received, within 48 hours is waived for **Infectious Disease.** Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

No **Illness Loss of Life Benefit** will be payable, however, if an **Accidental Death Indemnity Benefit** is payable under the policy, or if, as a direct result of participation in the same **Covered Activity,** an **HIV Positive Benefit** was paid to the **Insured Person** under the policy.

IV. The section entitled **"C. DEPENDENT BENEFIT",** appearing under **PART I.,** is deleted and replaced by the following.

C. DEPENDENT BENEFIT (PER DEPENDENT CHILD)

We will pay the **Dependent Benefit Amount** shown in the **Schedule** for each **Dependent Child** if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy. We may make payment directly to the **Dependent Child's:** (1) custodian; or (2) to an individual or institution appearing to us to have assumed custody or principal support of the **Dependent Child** if: (a) the **Dependent Child** is a minor, or in our opinion is not competent to give a valid receipt for payment due him or her; and (b) no request for payment has been received by us from a duly appointed guardian or other legally appointed representative. Payment made in this manner will release us from all liability to the extent of any payment made.

"Dependent Child" means any unmarried child of the **Insured Person** who was dependent upon the **Insured Person** and claimed on the **Insured Person's** final tax return.

V. The section entitled **"C. PERMANENT PHYSICAL IMPAIRMENT BENEFIT",** appearing under **PART II.,** is deleted and replaced by the following.

C. OPTIONAL PERMANENT PHYSICAL IMPAIRMENT BENEFIT

If this **Optional Permanent Physical Impairment Benefit** is selected by the **Participating Organization** as indicated in the **Schedule** and the **Optional Permanent Physical Impairment Benefit** becomes payable under the policy, we will pay an **Optional Permanent Physical Impairment Benefit** if **Injury** to an **Insured Person** results in an **Optional Permanent Physical Impairment** and the **Insured Person** participates in an approved physical rehabilitation program if his or her physical condition so warrants.

To Determine the Benefit Payable

The **Insured Person's Permanent Physical Impairment** will be assigned an impairment value by an examining **Physician.** This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association's "Guide To The Evaluation of Permanent Impairment." This percentage value will be applied to the **Optional Permanent Physical Impairment Benefit Principal Sum** shown in the **Schedule** to determine the **Optional Permanent Physical Impairment Benefit** dollar amount payable under the policy.

Any **Optional Permanent Physical Impairment Benefit** paid or payable hereunder will be in addition to any **Accidental Dismemberment Benefit** or **Vision Impairment Benefit** paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum or benefit amount shown in the **Schedule** for these **Benefits.**

If the **Insured Person** has a physical impairment prior to the time of loss, the impairment value that represents the pre-existing condition will be deducted from the **Permanent Physical Impairment** evaluation.

"Permanent Physical Impairment " means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or non progressive by the **Physician** at the time an evaluation is made.

VI. The sections entitled **"A. TOTAL DISABILITY BENEFITS"** and **"B. PARTIAL DISABILITY BENEFITS"**, appearing under **PART III.**, are deleted and replaced by the following.

A. TOTAL DISABILITY BENEFITS

(1) If **Injury** or **Illness** to an **Insured Person** results in **Total Disability,** we will pay the **Total Disability Weekly Income Benefit** shown in the **Schedule** for the first 28 days of **Total Disability.**

(2) If **Total Disability** continues beyond 28 days, we will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits paid or payable to the **Insured Person** from any workers' compensation act or similar law and **Other Valid and Collectible Insurance,** not to exceed the **Total Disability Maximum Weekly Amount** shown in the **Schedule,** for each week the **Insured Person** is **Totally Disabled** up to a maximum of 260 weeks.

(3) The minimum benefit payable for **Total Disability** will be the **Total Disability Minimum Weekly Amount** shown in the **Schedule.**

(4) If an **Insured Person** is approved for disability retirement by the Public Employee Retirement Administration Commissioner, or otherwise retires, all eligibility for **Total Disability** terminates on the effective date of such retirement.

B. PARTIAL DISABILITY BENEFITS

(1) If **Injury** or **Illness** to an **Insured Person** results in **Partial Disability,** we will pay the **Partial Disability Weekly Income Benefit** shown in the **Schedule** for the first 28 days of **Partial Disability.**

(2) If **Partial Disability** continues beyond 28 days, we will pay 50% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits paid or payable to the **Insured Person** from any workers' compensation act or similar law and **Other Valid and Collectible Insurance,** not to exceed the **Partial Disability Maximum Weekly Amount** shown in the **Schedule,** for each week the **Insured Person** is **Partially Disabled** up to a maximum of 52 weeks.

(3) The minimum benefit payable for **Partial Disability** will be the **Partial Disability Minimum Weekly Amount** shown in the **Schedule.**

(4) If an **Insured Person** is approved for disability retirement by the Public Employee Retirement Administration Commissioner, or otherwise retires, all eligibility for **Partial Disability** terminates on the effective date of such retirement.

VII. The section entitled **PART V. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT** is deleted and replaced by the following.

PART V. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT

We will pay a **Weekly Permanent Physical Impairment Benefit** if: (1) **Injury** to an **Insured Person** results in a **Permanent Physical Impairment;** and (2) it is determined that the **Insured Person** has a **Permanent Physical Impairment** percentage value of 50% or greater for purposes of the **Permanent Physical Impairment Benefit.** This **Weekly Permanent Physical Impairment Benefit** will begin in the 261st week from the date of participation in the **Covered Activity** which caused the **Injury** and will continue to be paid weekly for the remainder of the **Insured Person's** lifetime.

The **Weekly Permanent Physical Impairment Benefit** will be determined by multiplying the **Weekly Income Benefit** amount payable on the 29th day of **Total Disability,** as determined under **Weekly Income Benefits** section of the policy, by the percentage value of the **Insured Person's Permanent Physical Impairment.**

Example: If the **Total Disability Weekly Income Benefit** payable on the 29th day of **Total Disability** is $600.00 and the **Insured Person's Permanent Physical Impairment** percentage value is 70%, the lifetime **Weekly Permanent Physical Impairment Benefit** would be $420 per week ($600 x 70% = $420).

The **Permanent Physical Impairment** rating used to determine the **Weekly Permanent Physical Impairment Benefit** is final upon initiation of **Weekly Permanent Physical Impairment Benefits.** Subsequent changes in the **Permanent Physical Impairment** rating, if any, will not affect the **Weekly Permanent Physical Impairment Benefits** paid or payable.

Weekly Permanent Physical Impairment Benefits will be paid in addition to any benefits paid or payable under the policy.

VIII. The section entitled **"C. 24 HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT",** appearing under **PART VIII.,** is deleted and replaced by the following.

C. 24 HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This **24 Hour Accidental Death and Dismemberment Benefit** is only provided under the policy if it is selected by the **Participating Organization** and a benefit amount is indicated on the **Schedule.** It is payable if a Covered Person suffers an injury at any time, whether it be during a **Covered Activity** or not, that results in the Covered Person's accidental death or dismemberment such that:

(1) an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** is payable under the policy, or

(2) an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** would otherwise be payable under the policy but for the injury not being suffered during a **Covered Activity.**

The benefit amount payable will be equal to the **24 Hour Accidental Death and Dismemberment Benefit** or the **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** amount indicated in the **Schedule.**

Any **24 Hour Accidental Death and Dismemberment Benefit** payable is in addition to any **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** payable under the policy.

"Covered Person", as used in this benefit, means all people who are listed on the **Participating Organization's** roster. The roster will be maintained and periodically updated by the **Participating Organization**. The roster will be kept on file with the **Participating Organization.**

IX. The section entitled **"D. NON-COVERED ACTIVITY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT"**, appearing under **PART VIII.**, is deleted and replaced by the following.

D. NON-COVERED ACTIVITY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This **Non-Covered Activity Accidental Death and Dismemberment Benefit** is only provided under the policy if it is selected by the **Participating Organization** and a benefit amount is indicated on the **Schedule.** It is payable if a Covered Person suffers an injury during a non-covered activity that results in the Covered Person's accidental death or dismemberment such that an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** would otherwise be payable under the policy but for the injury not being suffered during a **Covered Activity.** The benefit amount payable will be equal to the **Non-Covered Activity Accidental Death and Dismemberment Benefit** amount indicated in the **Schedule.**

The **Non-Covered Activity Accidental Death and Dismemberment Benefit** is not available under the policy if the **24 Hour Accidental Death and Dismemberment Benefit** is provided under the policy.

"Covered Person", as used in this benefit, means all people who are listed on the **Participating Organization's** roster. The roster will be maintained and periodically updated by the **Participating Organization**. The roster will be kept on file with the **Participating Organization.**

This endorsement takes effect on 02/01/2008 12:01 A.M., Standard Time at Alexandria, VA and it expires concurrently with the policy and is subject to all of the provisions, definitions, limitations, and conditions of the policy not inconsistent herewith.

Attached to and made part of Policy No. VFP 2347-7994C-04 / 00 issued to Appalachian Search and Rescue Conference, Inc by the National Union Fire Insurance Company of Pittsburgh, PA. but the same shall not be binding on the Company unless countersigned by its duly authorized agent.

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

President

Secretary

Countersigned by _____
Licensed Resident Agent
(Where required by law)

NATIONAL UNION
FIRE INSURANCE COMPANY
OF PITTSBURGH, PA.
A CAPITAL STOCK COMPANY

Home Offices: Pittsburgh, PA 15222
Executive Offices: 70 Pine Street, New York, NY 10270
212/770-7000

FELONIOUS ASSAULT BENEFIT RIDER

This rider is made a part of the summary of coverage to which it is attached. It modifies the summary of coverage as set forth below. All other provisions of the policy remain in full force and effect. In the event of any conflict between this rider and the policy, this rider shall govern.

Felonious Assault Benefit Percentage of Principal Sum Amount. We will pay a benefit under this Rider when the **Insured Person** suffers one or more losses for which benefits are payable under the **Accidental Death Indemnity Benefit, Accidental Dismemberment Benefit, Cosmetic Disfigurement Resulting from Burns Benefit, Permanent Physical Impairment Benefit, Vision Impairment Benefit** provided by the **Policy** as a result of a **Felonious Assault** that is directed at the **Insured Person** while he or she is participating in a **Covered Activity**.

The amount payable under this Rider is an additional 50 % of the total amount payable under all the benefits specified above. Only one benefit is payable under this Rider for all losses as a result of the same **Felonious Assault**.

Felonious Assault - as used in this Rider, means any willful or unlawful use of force upon the **Insured Person**: (1) with the intent to cause bodily injury to the **Insured Person**; and (2) that results in bodily harm to the **Insured Person**; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

This rider takes effect on 02/01/2008 12:01 A.M., Standard Time at Alexandria, VA.

Attached to and made a part of Policy No. VFP 2347-7994C-04 / 00 issued to Appalachian Search and Rescue Conference, Inc by the National Union Fire Insurance Company of Pittsburgh, PA but the same shall not be binding on the Company unless countersigned by its duly authorized agent.

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

President

Secretary

NATIONAL UNION
FIRE INSURANCE COMPANY
OF PITTSBURGH, PA.
A CAPITAL STOCK COMPANY

Home Offices: Pittsburgh, PA 15222
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212/770-7000

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT RIDER

This rider is made a part of the summary of coverage to which it is attached. It modifies the summary of coverage as set forth below. All other provisions of the policy remain in full force and effect. In the event of any conflict between this rider and the policy, this rider shall govern.

If an **Insured Person:**

1. suffers an **Injury** or **Illness** that is payable under the **Policy** and which results in a permanent and irrevocable loss;
2. did not, prior to the date of the Covered Activity, require **Home Alteration** or **Vehicle Modification**; and
3. as a direct result of such loss(es) is now required to make a **Home Alteration** and/or **Vehicle Modification**;

we will pay **Covered Home Alteration and Vehicle Modification Expenses** that are incurred within one year after the date of the accident or the onset of the Illness causing such loss(es), up to a maximum of $ 15,000 , for all such losses caused by the same accident or **Illness**.

Covered Home Alteration and Vehicle Modification Expenses – means one-time expenses that:

1) are charged for:
   a) alterations to the **Insured Person's** residence that are necessary to make the residence accessible and habitable for an impaired individual; and
   b) modifications to a motor vehicle owned or leased by the **Insured Person** or modifications to a motor vehicle newly purchased for the Insured Person that are necessary to make the vehicle accessible to and/or driveable by the **Insured Person**; and
2) do not include charges that would not have been made if no insurance existed;
3) and do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the **Insured Person's** residence and the modifications to his or her motor vehicle are:

1) made on behalf of the **Insured Person**;
2) recommended by a nationally-recognized organization providing support and assistance to impaired individuals;
3) carried out by individual experienced in such alterations and modifications;
4) in compliance with any applicable laws or requirements for approval by the appropriate government authorities; and
5) is agreed to and approved by us

We will pay any **Home Alteration** and **Vehicle Modification** expenses incurred by an **Insured Person** in excess of benefits paid or payable under any workers' compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.

This rider takes effect on 02/01/2008 12:01 A.M., Standard Time at Alexandria, VA.

Attached to and made a part of Policy No. VFP 2347-7994C-04 / 00 issued to Appalachian Search and Rescue Conference, Inc by the National Union Fire Insurance Company of Pittsburgh, PA but the same shall not be binding on the Company unless countersigned by its duly authorized agent.

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

President

Secretary

NATIONAL UNION
FIRE INSURANCE COMPANY
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This summary of coverage furnished by National Union Fire Insurance Company (called "we", "our" or "us" in this summary of coverage) describes the coverage that will be provided for all those persons called **Insured Person**s as defined in this summary of coverage. Coverage will be provided for losses described herein subject to the terms of the Master Policy (called "the policy" in this summary of coverage.) This summary of coverage is issued to the **Participating Organization** named in the **Schedule**.

This summary of coverage is not a contract of insurance. The complete terms and conditions governing each **Insured Person**'s coverage are in the policy issued to the **Policyholder** named in the **Schedule**. The policy may be changed or terminated without the consent of or notice to each **Insured Person**.

CONSIDERATION - TERM

Coverage under the policy is provided in consideration of the payment of the premium by **the Participating Organization**. The premium due is shown in the **Schedule**. The term of coverage for such **Participating Organization** will begin on the Effective Date and end on the Expiration Date as shown in the **Schedule**. All periods of insurance will begin and end at 12:01 AM Standard Time at the address of the **Participating Organization**.

RENEWAL

Coverage may be renewed by us for further consecutive terms by the payment of our premium rate in effect at the time of renewal. If this coverage is not renewed, insurance will stop on the date to which premiums have been paid subject to the Grace Period provision.

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

An **Insured Person**'s coverage will take effect on the later of: (1) the Effective Date shown in the **Schedule**; or (2) the date he or she becomes an **Insured Person** as defined in this summary of coverage.

An **Insured Person**'s coverage will end on the earliest of: (1) the date the policy terminates; (2) the date he or she is no longer an **Insured Person** as defined in this summary of coverage; or (3) the date the **Participating Organization's** coverage ends.

Termination of coverage will not affect any loss resulting from participation in a **Covered Activity** when such participation occurred prior to the date of termination.

National Union Fire Insurance Company of Pittsburgh, Pennsylvania has caused this summary of coverage to be signed by its President and Secretary.

President

Secretary

GENERAL SUMMARY OF COVERAGE DEFINITIONS
(additional defined terms can be found throughout the summary of coverage)

Consumer Price Index - means the consumer price index published by the U.S. Department of Labor's Bureau of Labor Statistics for All Urban Consumers, All Items (CPI-U).

Covered Activity - means any activity, including travel directly to and from such activity, which is a normal duty of an **Insured Person**, including any: (1) emergency response for fire suppression and rescue or emergency medical activity; (2) training exercise which simulates an emergency and where active physical participation is required; (3) **Firematic Events or Contests**; (4) class room training; (5) fund-raising activities including athletic activities solely for the purpose of raising funds for the **Participating Organization** or other non-profit organization when such fund-raising is performed as an activity of the **Participating Organization**, except any activity in football, ice or field hockey, lacrosse, soccer or boxing; (6) official functions attended primarily by members of the **Participating Organization** for which the purpose is to further the business of the **Participating Organization** (i.e. installation dinners, banquets, etc.); (7) official conventions, conferences or meetings of emergency fire, rescue or medical personnel attended by the **Insured Person** on behalf of the **Participating Organization** including personal travel or activities undertaken attendant to such convention, conference or meeting; and (8) participation in covered athletic events while otherwise on the premises of the **Participating Organization** for the performance of a normal duty.

The **Covered Activity** must be performed at the direction, or with the knowledge, of an officer of the **Participating Organization**, unless immediate action is required of the **Insured Person** at the scene of an emergency not on behalf of the **Participating Organization** or any other organization.

Firematic Events or Contests - means practice or participation in an organized event intended to enhance the **Insured Person's** skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental: (1) apparatus pumping contests; (2) battle of the barrel; (3) antique pumping; (4) hose rolling contests; (5) equipment donning contests; (6) bucket brigades; (7) ladder climbs; (8) tug of war contests; and (9) apparatus operation rodeos.

Hospital - means a facility which: (1) is operated according to law for the care and treatment of injured and sick persons; (2) has organized facilities for diagnosis and surgery; (3) has 24 hour nursing service by registered nurses (R.N.'s); (4) is supervised by one or more **Physicians**; and (5) which is not primarily a rest home, nursing home, convalescent home or home for the aged.

Illness - means any disease, sickness, or infection of an **Insured Person** while coverage under the policy is in force as to the **Insured Person**. The **Illness** must: 1) manifest itself during a specific **Covered Activity** with the result that the **Insured Person** interrupts his or her participation in such **Covered Activity** in order to receive immediate medical treatment; or 2) directly result from participation in a **Covered Activity** and also result in the **Insured Person** receiving medical treatment within 48 hours of participation in such **Covered Activity**. The requirement that medical treatment be received within 48 hours is waived for **Infectious Diseases**. Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

Immediate Family Member - means the **Insured Person's** spouse, child, parent, brother or sister.

Infectious Disease - means a disease included within the list of potentially life-threatening infectious diseases, developed by the Secretary of Health and Human Services, pursuant to Title XXVI of the Public Health Service Act, such as hepatitis, clostridium, rubella, and tuberculosis.

Injury(ies) - means accidental bodily injury sustained by the **Insured Person**: (1) during and resulting from an **Insured Person's** participation in a specific **Covered Activity** while coverage under the policy is in force as to the **Insured Person**; (2) which directly (independent of sickness, disease, mental incapacity or any other cause) causes a loss to the **Insured Person**; and (3) which is not otherwise defined as an **Illness**.

The term **Injury** includes, but is not limited to, hernia, back strain or sprain, heat exhaustion, and over-exertion. The term **Injury**, or the purposes of this policy, shall not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

Insured Person - means any officially designated member of a **Participating Organization** while acting as: (1) a volunteer member for the **Participating Organization**; (2) any junior member or member in training; (3) any commissioner, director, trustee or other similar position associated with the **Participating Organization**; (4) any bystander deputized at the time of the emergency by an official of the **Participating Organization** to assist in an emergency, but only during the actual emergency; (5) any auxiliary member; (6) any non-member who is requested to participate by the auxiliary or **Participating Organization**; and (7) any member who receives remuneration for "on call" duty or out of pocket expenses subject to the following:

An **Insured Person** will not include a member who looks to the **Participating Organization** for their primary source of income while acting within the scope of their employment unless the policy is specifically endorsed to provide coverage for career members. A member will be deemed to look to the **Participating Organization** for their primary source of income if they receive remuneration for "on call" duty of more than 25 hours per week.

Other Valid and Collectible Insurance - means any: (1) group plan, program, or insurance policy; (2) any other group hospital, surgical or medical benefit plan; (3) union welfare plans or group employer or employee benefit programs; or (4) any no-fault automobile insurance plan or similar law. **Other Valid and Collectible Insurance** will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

Out-Patient Physical Therapy - means rehabilitative physical therapy which is: 1) received without being confined overnight in a **Hospital** as a registered bed patient; 2) an approved therapy program; 3) necessary for the rehabilitation of an **Insured Person** from an **Injury** or an **Illness** for which he or she was confined in a **Hospital** for treatment; 4) administered by a licensed physical therapist; and 5) monitored by a **Physician**.

Participating Organization - means a non-profit emergency service organization or political subdivision who elects coverage under the policy and pays the required premium. The **Participating Organization** is named in the **Schedule**. Coverage for such **Participating Organization** will be in force at 12:01 AM on the Effective Date shown in the **Schedule** subject to payment of the required premium. Coverage is limited to **Insured Persons** of any fire, emergency, rescue or ambulance departments of the municipality or political subdivision.

Permanent Physical Impairment - means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or nonprogressive by the **Physician** at the time an evaluation is made.

Physician - means any duly licensed medical practitioner: (1) who is acting within the scope of his or her license; and (2) who is not the **Insured Person** or an **Immediate Family Member**.

Reasonable and Customary Expense - means an expense which: (1) is charged for treatment, supplies or medical services medically necessary to treat the **Insured Person's** condition; (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Schedule - means the Schedule of Coverages which is attached to and made part of this summary of coverage.

PART I. LOSS OF LIFE BENEFITS

A. ACCIDENTAL DEATH BENEFITS

(i) **Accidental Death Indemnity Benefit.** We will pay the **Accidental Death Indemnity Benefit** shown in the **Schedule** if **Injury** to an **Insured Person** results in the **Insured Person's** death.

(ii) **Seat Belt Benefit.** If an **Accidental Death Indemnity Benefit** is payable hereunder and the accident which caused the **Insured Person's** accidental death occurred while the **Insured Person** was wearing a properly fastened automotive seat belt, we will pay an additional amount equal to **Seat Belt Benefit Amount** shown in the **Schedule**. This **Seat Belt Benefit** is not payable for **Injuries** sustained by an **Insured Person** while standing inside or on the tailboard of any vehicle.

B. ILLNESS LOSS OF LIFE BENEFIT

We will pay the **Illness Loss of Life Benefit** shown in the **Schedule** if **Illness** causes loss of life of the **Insured Person**.

No **Illness Loss of Life Benefit** will be payable, however, if an **Accidental Death Indemnity Benefit** is payable under the policy, or if, as a direct result of participation in the same **Covered Activity**, an **HIV Positive Benefit** was paid to the **Insured Person** under the policy.

C. DEPENDENT BENEFIT

We will pay the **Dependent Benefit Amount** shown in the **Schedule** to the legal guardian of each **Dependent Child** if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy.

"Dependent Child" means any unmarried child of the **Insured Person** who was dependent upon the **Insured Person** and claimed on the **Insured Person's** final tax return.

D. SPOUSAL SUPPORT BENEFIT

We will pay the **Spousal Support Benefit Amount** shown in the **Schedule** to the **Insured Person's** surviving spouse if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy.

E. MEMORIAL BENEFIT

We will pay the **Memorial Benefit Amount** shown in the **Schedule** to the **Participating Organization,** to be used to cover final expenses incurred by the **Participating Organization** on behalf of the **Insured Person,** if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy.

PART II. LUMP SUM LIVING BENEFITS

A. ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to an **Insured Person** shall result in any one of the losses listed below, we will pay the indicated percentage for the loss suffered, of the **Accidental Dismemberment Principal Sum** shown in the **Schedule**. If the **Insured Person** suffers more than one loss as a result of any one accident, only one amount, the largest, will be paid.

For Loss of:	% of Accidental Dismemberment Principal Sum Payable
Both Hands or Both Feet	100
One Hand and One Foot	100
Entire Sight of Both Eyes	100
One Hand and Entire Sight of One Eye	100
One Foot and Entire Sight of One Eye	100
Speech and Hearing	100
One Arm or One Leg	75
Speech or Hearing	50
One Hand or One Foot	50
Entire Sight of One Eye	50
Both Thumbs	10
One Thumb	5
Each Joint of a Finger or Toe	1

"Loss" means, with reference to the foot, a complete severance through or above the ankle joint; with reference to the hand, the complete severance of the distal, proximal or medial phalanx of four fingers; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the thumb, the complete severance at the metacarpophalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (where applicable) medial phalanx. **Loss** of speech or hearing means the total and irrecoverable loss of speech and/or hearing. **Loss** of sight means the total and irrecoverable loss of sight.

B. VISION IMPAIRMENT BENEFIT

If **Injury** to an **Insured Person** shall result in **Permanent Damage** to the **Insured Person's** eyesight, we will pay the indicated percentage, from the vision impairment table below, of the **Vision Impairment Benefit** shown in the **Schedule** for each eye impaired based upon the degree of vision impairment to each eye. This table shall apply separately to each eye.

Vision Impairment	% of Vision Impairment Benefit Payable Per Each Eye
20/20	0.00%
20/30	2.75%
20/40	5.50%
20/50	8.25%
20/60	11.00%
20/80	16.50%
20/100	22.00%
20/120	28.00%
20/150	36.00%
20/180	44.50%
20/200 or poorer	50.00%

If the sight of an eye is less than 20/20 before the **Permanent Damage**, we will pay a benefit based only upon the additional impairment due to the **Injury**. In no event will we pay both **Accidental Dismemberment Benefits** for a **Loss** of sight and **Vision Impairment Benefits** for **Injury** to the same eye sustained while participating in the same **Covered Activity**.

"Permanent Damage" means, with reference to the eyes, irreparable **Injury** which results in permanently impaired vision, but not in total and irrecoverable loss of sight.

C. PERMANENT PHYSICAL IMPAIRMENT BENEFIT

We will pay a **Permanent Physical Impairment Benefit** if **Injury** to an **Insured Person** results in a **Permanent Physical Impairment** and the **Insured Person** participates in an approved physical rehabilitation program if his or her physical condition so warrants.

To Determine the Benefit Payable

The **Insured Person's Permanent Physical Impairment** will be assigned an impairment value by an examining **Physician**. This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association's "Guide To The Evaluation of Permanent Impairment." This percentage value will be applied to the **Permanent Physical Impairment Benefit Principal Sum** shown in the **Schedule** to determine the **Permanent Physical Impairment Benefit** dollar amount payable under the policy.

Any **Permanent Physical Impairment Benefit** paid or payable hereunder will be in addition to any **Accidental Dismemberment Benefit** paid or payable under the Policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these **Benefits.**

If the **Insured Person** has a physical impairment prior to the time of loss, the impairment value that represents the pre-existing condition will be deducted from the **Permanent Physical Impairment** evaluation.

"Permanent Physical Impairment" means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or non progressive by the **Physician** at the time an evaluation is made.

D. COSMETIC DISFIGUREMENT RESULTING FROM BURNS BENEFIT

We will pay benefits if, as the result of **Injury**, an **Insured Person** suffers from cosmetic disfigurement due to a burn that is classified as a full thickness or third degree burn.

To Determine the Benefit Payable

Any **Cosmetic Disfigurement from Burns Benefit** payable will be based on a percentage of the **Cosmetic Disfigurement from Burns Principal Sum** shown in the **Schedule** and depend on the area of the body which was burned. The benefit payable for any one loss is determined by the following formula:

(1) First the area of the body that was burned is assigned an area classification factor by using the table shown below. Each body part is assigned a classification relative to its visual exposure (i.e. the higher the classification, the more visual exposure);

(2) This area classification factor is multiplied by the percentage of body surface actually burned. The attending **Physician** will determine the percentage applicable to each burn. The table below lists the maximum allowance percentage for body surface burned for each area classification;

(3) Steps 1 and 2 will produce an arithmetic factor that will be multiplied by the **Cosmetic Disfigurement from Burns Principal Sum** to determine the percentage of the **Cosmetic Disfigurement from Burns Principal Sum** payable under this benefit. For example, by using the **Cosmetic Burn Schedule** shown below:

(a) if the entire surface of the right hand and forearm were burned the benefit would be 5x4.5%=22.5% of the **Cosmetic Disfigurement from Burns Principal Sum** payable; or

(b) if 50% of surface of the right hand and forearm were burned the benefit would be 5x2.25% (which is 50% of 4.5)=11.25% of the **Cosmetic Disfigurement from Burns Principal Sum** payable.

The following table is a burn schedule from which benefits can be determined. This table only represents the maximum % of the **Cosmetic Disfigurement from Burns Principal Sum** payable for any one covered loss. If the **Insured Person** suffers burns in more than one area as a result of any one accident, benefits will not exceed more than 100% of the **Cosmetic Disfigurement from Burns Principal Sum**.

Cosmetic Burn Schedule

Body Part	Area Classification	Maximum Allowable % for Area Surface Burned	Maximum % of Cosmetic Disfigurement from Burns Principal Sum
Face, Neck, Head	11	9.0%	99.0%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18.0%	36.0%
Torso (Back)	2	18.0%	36.0%
Thigh (Right)	1	9.0%	9.0%
Thigh (Left)	1	9.0%	9.0%
Lower Leg (Right) (below knee)	3	9.0%	27.0%
Lower Leg (Left) (below knee)	3	9.0%	27.0%

The percentage shown is based on 100% of the Body Part identified being burned. Please refer to the **Schedule** for the amount of the **Cosmetic Disfigurement from Burns Principal Sum**.

Any **Cosmetic Disfigurement from Burns Benefit** paid or payable hereunder will be in addition to any **Accidental Dismemberment Benefit** or **Permanent Physical Impairment Benefit** paid or payable under the Policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these **Benefits.**

E. HIV POSITIVE LUMP SUM LIVING BENEFIT

We will pay the **HIV Positive Benefit** shown in the **Schedule** if, as a direct result of participation in a specific **Covered Activity**, an **Insured Person** tests **HIV Positive.**

"HIV" means human immunodeficiency virus.

"HIV Positive" means the presence of **HIV** antibodies in the blood of an **Insured Person** as substantiated through both a positive screening test (enzyme-linked immunosorbent assay, ELISA) and a positive supplemental test such as Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positivity as specified by the manufacturer(s).

In the event that an **HIV Positive Benefit** and a **Illness Loss of Life Benefit** are both payable under the policy as a result of any one **Illness** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

PART III. WEEKLY INCOME BENEFITS

A. TOTAL DISABILITY BENEFITS

(1) If **Injury** or **Illness** to an **Insured Person** results in **Total Disability**, we will pay the **Total Disability Weekly Income Benefit** shown in the **Schedule** for the first 28 days of **Total Disability**.

(2) If **Total Disability** continues beyond 28 days, we will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any workers' compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the **Total Disability Maximum Weekly Amount** shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of 260 weeks.

(3) The minimum benefit payable for **Total Disability** will be the **Total Disability Minimum Weekly Amount** shown in the **Schedule**.

B. PARTIAL DISABILITY BENEFITS

(1) If **Injury** or **Illness** to an **Insured Person** results in **Partial Disability**, we will pay the **Partial Disability Weekly Income Benefit** shown in the **Schedule** for the first 28 days of **Partial Disability**,

(2) If **Partial Disability** continues beyond 28 days, we will pay 50% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any workers' compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the **Partial Disability Maximum Weekly Amount** shown in the **Schedule**, for each week the **Insured Person** is **Partially Disabled** up to a maximum of 52 weeks.

(3) The minimum benefit payable for **Partial Disability** will be the **Partial Disability Minimum Weekly Amount** shown in the **Schedule**.

C. DISABILITY BENEFITS GENERAL

If an **Insured Person** is **Totally Disabled** or **Partially Disabled** for less than a week, we will pay 1/7 of the benefit otherwise payable for each full day the **Insured Person** is so disabled.

The amount of **Total Disability Benefits** or **Partial Disability Benefits** payable to an **Insured Person** who is **Totally Disabled** or **Partially Disabled** may be increased after **Total Disability Benefits** or **Partial Disability Benefits** have been paid to that **Insured Person** for at least 52 consecutive weeks. The increase will equal the percentage increase, if any, in the **Consumer Price Index** for the preceding calendar year. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the **Covered Activity** which caused the **Injury** or **Illness**, or to the **Total Disability Benefit** or **Partial Disability Benefit,** whichever results in the higher benefit to the **Insured Person**. Any increase in benefits will become effective on July 1 next following the 52 week benefit period. Successive annual increases, if any, on July 1 of each subsequent year will be compounded.

In the event that benefits are payable for both **Total Disability** and **Partial Disability** resulting from **Injury** or **Illness** sustained while participating in the same **Covered Activity**, the maximum benefit period for all benefits is 260 weeks.

Periods of **Total Disability** or **Partial Disability** separated by less than five (5) years will be considered one period of disability unless due to separate and unrelated causes.

Average Weekly Wage – means an average weekly wage determined by the greater of: 1) the total of wages, salaries, tips, and commissions, etc., for the calendar year immediately preceding the year in which the loss occurred; 2) the average weekly wage earned in the 12 months preceding the loss; 3) the annualized weekly wage earned in the 3 months preceding the loss; or 4) for the self-employed, the amount taken from Schedule C, E, or F which is reported on page one (1) of IRS Form 1040 as net taxable income, excluding rental, investment or passive income. The **Average Weekly Wage** will be verified by the **Insured Person's** employer and/or tax records.

Partial Disability, Partially Disabled - means an **Insured Person's** inability to do one or more, but not all, of the material and substantial duties of his or her regular occupation. The **Insured Person** must be under the regular care of a **Physician** during **Partial Disability**.

Total Disability, Totally Disabled - means an **Insured Person's** inability to perform all of the material and substantial duties of his or her regular occupation. The **Insured Person** must be under the regular care of a **Physician** during **Total Disability**.

PART IV OCCUPATIONAL RETRAINING BENEFIT

We will pay for **Covered Retraining Expenses**, up to the **Occupational Retraining Benefit Maximum Amount** shown in the **Schedule**, if, as a result of **Injury or Illness**, an **Insured Person** is rendered **Permanently Totally Disabled** and chooses to enroll in an institution of higher learning or professional or trade training program. The objective of any professional or trade training program must be to return the **Insured Person** to work in an occupation to which he/she is suited. The professional or trade training program must be agreed upon by us and the **Insured Person**.

"Covered Retraining Expenses" includes, but is not limited to, expenses for tuition, books and any other training materials required by the institution of higher learning or professional or trade training program.

"Permanently Totally Disabled" means that the **Insured Person** is permanently unable to perform the material and substantial duties of his or her occupation.

PART V. WEEKLY PERMANENT PHYSICAL IMPAIRMENT BENEFIT

We will pay a **Weekly Permanent Physical Impairment Benefit** if: 1) **Injury** to an **Insured Person** results in a **Permanent Physical Impairment**; and 2) it is determined that the **Insured Person** has a **Permanent Physical Impairment** percentage value of 50% or greater for purposes of the **Permanent Physical Impairment Benefit**. This **Weekly Permanent Physical Impairment Benefit** will begin in the 261st week from the date of participation in the **Covered Activity** which caused the **Injury** and will continue to be paid weekly for the remainder of the **Insured Person's** lifetime.

The **Weekly Permanent Physical Impairment Benefit** will be determined by multiplying the **Weekly Income Benefit** amount payable on the 29th day of **Total Disability**, as determined under **Weekly Income Benefits** section of the policy, by the percentage value of the **Insured Person's Permanent Physical Impairment**.

> Example: If the **Total Disability Weekly Income Benefit** payable on the 29th day of **Total Disability** is $600.00 and the **Insured Person's Permanent Physical Impairment** percentage value is 70%, the lifetime **Weekly Permanent Physical Impairment Benefit** would be $420 per week ($600 x 70% = $420).

Weekly Permanent Physical Impairment Benefits will be paid in addition to any benefits paid or payable under the policy.

PART VI. OPTIONAL WEEKLY PERMANENT PHYSICAL IMPAIRMENT COLA BENEFIT

If this **Optional Weekly Permanent Physical Impairment Cola Benefit** is selected by the **Participating Organization** as indicated on the **Schedule** and **Weekly Permanent Physical Impairment Benefits** become payable under the policy, the amount payable will be increased after benefits have been paid for at least 52 consecutive weeks. The percentage of increase will equal the increase in the **Consumer Price Index.** This increased benefit payment will begin on July 1, following the 52 week benefit period. Successive annual increases on July 1 of each year will be compounded.

PART VII. MEDICAL EXPENSE BENEFITS

A. MEDICAL EXPENSE BENEFIT

We will pay the **Reasonable and Customary Expenses** incurred by an **Insured Person** as a result of an **Injury** or **Illness** for necessary:

(1) medical, **Hospital** or surgical treatment;
(2) **Home Health Care**;
(3) nursing services prescribed and monitored by a **Physician**;
(4) Postexposure Prophylaxis Protocol (PEP) treatment, when such treatment is advised by the attending **Physician**;
(5) **Infectious Disease** screening test(s); or
(6) Postexposure preventive inoculations as a result of participation in a **Covered Activity**.

We will pay the medical expense benefits subject to the **Participating Organization's** choice of 1,2, or 3 below:

1. If "1" on the **Schedule** is marked with an "X", we will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any workers' compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable workers' compensation act or similar law, but are covered under the policy, we will pay such benefits.

2. If "2" on the **Schedule** is marked with an "X", we will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any workers' compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.

3. If "3" on the **Schedule** is marked with an "X", we will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any other group insurance, no fault automobile insurance plan or similar law, or any workers' compensation act or similar law.

All medical expense benefits will be paid subject to the terms and limits of each applicable part.

We will not pay more than the **Medical Expense Maximum Amount** shown in the Schedule for any one accident or **Illness**.

"Home Health Care" means those nursing and other home health care services provided to an **Insured Person** in his or her place of residence. **Home Health Care** must be: (1) performed by a **Home Health Care Practitioner**; (2) in lieu of confinement in a **Hospital** or nursing facility; and (3) pursuant to the orders of the attending **Physician**. Such attending **Physician's** orders must be written and include a plan of care which must be reviewed and approved by the **Physician**.

"Home Health Care Practitioner" means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a **Home Health Care Practitioner** unless such practitioner is: (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received; and (2) not an **Insured Person** or an **Immediate Family Member**.

B. COSMETIC PLASTIC SURGERY BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred if an **Insured Person** requires skin grafting or plastic surgery due to an **Injury** for which **Medical Expense Benefits** are paid or payable. We will not pay more than the **Cosmetic Plastic Surgery Maximum Amount** shown in the **Schedule** for any one accident.

C. POST TRAUMATIC STRESS DISORDER BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred, if, as the result of participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred, an **Insured Person** requires **Hospital** or medical treatment of a **Post-Traumatic Stress Disorder.** Treatment must be prescribed and monitored by a **Physician**. We will not pay more than the **Post Traumatic Stress Disorder Maximum Amount** shown in the **Schedule** for each **Insured Person** for any one **Covered Activity**.

"Post Traumatic Stress Disorder" - means emotional stress resulting from a **Traumatic Incident** experienced by an **Insured Person** which adversely affects the psychological and physical well-being of the **Insured Person**.

"Traumatic Incident" - means an abnormal experience, outside the range of usual human experiences and includes, but is not limited to: a) line-of-duty death or serious injury to other **Insured Persons**; b) a single incident having multiple casualties; c) death or serious injury of a child; and d) dealing with victims known to the **Insured Person**.

D. CRITICAL INCIDENT STRESS MANAGEMENT BENEFIT

We will pay the reasonable expenses incurred by a **Critical Incident Stress Management Team** when such services are: (1) requested and authorized by the **Participating Organization**; and (2) are required as a result of the **Insured Person's** participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred. Covered expenses are those for necessary transportation, meals, and lodging. We will not pay more than the **Critical Incident Stress Management Maximum Amount** which is shown in the **Schedule** regardless of the number of **Insured Persons** treated.

"Critical Incident Stress Management Team (CISMT)" - means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

E. FAMILY EXPENSE BENEFIT

If an **Insured Person** requires **Hospital** confinement for seven (7) or more consecutive days for an **Injury** or **Illness**, we will pay the **Family Expense Benefit** shown in the **Schedule** for each day of such **Hospital** confinement. This benefit will be payable retroactive to the first day of confinement, after the **Insured Person** has been confined for seven (7) consecutive days.

After such **Hospital** confinement, we will also pay 50% of the **Family Expense Benefit** shown in the **Schedule** for each day an **Insured Person** participates in **Out-Patient Physical Therapy** as a result of such **Injury** or **Illness**.

The **Family Expense Benefit** will be payable for a combined maximum of 26 weeks for any one accident or **Illness** regardless of whether it is paid at 100% or 50%.

PART VIII. OPTIONAL BENEFITS

A. WEEKLY HOSPITAL INDEMNITY BENEFIT

If **Weekly Income Benefits** are payable under the policy, we will also pay the **Weekly Hospital Indemnity Benefit** shown in the **Schedule** if the **Insured Person** eligible to receive the **Weekly Income Benefits** requires **Hospital** confinement or **Out-Patient Physical Therapy** for the same **Injury** or **Illness.**

This **Weekly Hospital Indemnity Benefit** starts on the first day the **Insured Person** is confined to a **Hospital** or begins **Out-Patient Physical Therapy**. If benefits are payable for less than a full week, we will pay 1/7 of the **Weekly Hospital Indemnity Benefit** shown in the **Schedule** for each day the **Insured Person** is confined in the **Hospital** or received **Out-Patient Physical Therapy**. This benefit will be limited to a maximum of 52 weeks for all **Illnesses** resulting from the same

Covered Activity or all **Injuries** resulting from the same accident.

B. OPTIONAL ADDITIONAL DISABILITY WEEKLY BENEFIT

If an **Insured Person** becomes **Totally Disabled** and is eligible for **Total Disability Benefits** under the policy, we will pay a one time additional weekly benefit equal to the **Additional Disability Weekly Benefit** shown in the **Schedule** for the first week the **Insured Person** is **Totally Disabled**. If the **Insured Person** is **Totally Disabled** for less than one week, we will pay 1/7 of the **Additional Disability Weekly Benefit** for each full day of **Total Disability**. We will pay the **Additional Disability Weekly Benefit** in addition to any other weekly benefit payable under the policy.

C. 24 HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This **24 Hour Accidental Death and Dismemberment Benefit** is only provided under the policy if it is selected by the **Participating Organization** and indicated on the **Schedule.** It is payable if an **Insured Person** suffers an injury at any time, whether it be during a **Covered Activity** or not, that results in the **Insured Person's** accidental death or dismemberment such that:

(1) an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** is payable under the policy, or
(2) an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** would otherwise be payable under the policy but for the injury not being suffered during a **Covered Activity**.

The benefit amount payable will be equal to the **Accidental Death Indemnity Benefit** or the **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** that is payable under the policy, or that otherwise would have been payable under the policy had the injury been suffered during a **Covered Activity**.

Any **24 Hour Accidental Death and Dismemberment Benefit** payable is in addition to any **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** payable under the policy.

D. NON-COVERED ACTIVITY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This **Non-Covered Activity Accidental Death and Dismemberment Benefit** is only provided under the policy if it is selected by the **Participating Organization** and indicated on the **Schedule.** It is payable if an **Insured Person** suffers an injury during a non-covered activity that results in the **Insured Person's** accidental death or dismemberment such that an **Accidental Death Indemnity Benefit** or an **Accidental Dismemberment Benefit** or a **Vision Impairment Benefit** would otherwise be payable under the policy but for the injury not being suffered during a **Covered Activity**. The benefit amount payable will be equal to the amount that would have been payable had the injury been suffered during a **Covered Activity**.

The **Non-Covered Activity Accidental Death and Dismemberment Benefit** is not available under the policy if the **24 Hour Accidental Death and Dismemberment Benefit** is provided under the policy.

OTHER COVERAGE WITH THIS COMPANY

If the **Insured Person** is covered under more than one similar policy issued by us, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

EXCLUSIONS

We will not cover any loss caused by or resulting from:

1) suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
2) injuries that happen while flying except: a) as a passenger on a commercial aircraft; or b) a passenger on any aircraft while taking part in a **Covered Activity**;
3) injuries that happen while flying as a crew member, or during parachute jumps from the aircraft;
4) war or any act of war, whether declared or undeclared;
5) Mental or emotional disorders, except as specifically provided for covered **Post Traumatic Stress Disorder**;
6) Treatment of alcoholism or drug addiction and any complications arising therefrom, except loss caused by **Injury** sustained during and resulting from a **Covered Activity**;
7) illness, except as provided by the policy;
8) military service of any state or country; or
9) any activity in football, ice hockey, field hockey, lacrosse, soccer and boxing.

GENERAL PROVISIONS

Entire Contract; Changes: The policy with the application and any attached papers is the entire contract between the **Policyholder** and us.

No change in the policy shall be valid until approved by one of our executive officers. Such approval must be noted on or attached to the policy. No agent may change the policy or waive any of its provisions.

Application, Statements: In the absence of fraud, all statements made by the **Policyholder** and **Participating Organization** will be considered representations and not warranties. No statement will be used to void the insurance or reduce benefits unless they appear in a written instrument signed by the **Policyholder** or the **Participating Organization**.

Grace Period: The policy has a 31 day grace period. This means if premium is not paid on or before the date is due, it may be paid during the following 31 days. During the grace period the policy will remain in force.

Notice of Claim: Written notice of claim must be given to us within 30 days after a covered loss occurs, or as soon as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to us at our Executive Offices or to one of our authorized agents.

Claim Forms: When we receive the notice of claim, we will send the claimant forms for proof of loss. If these forms are not furnished within 15 days, the claimant will meet the proof of loss requirements by giving us written proof of the nature and extent of the loss within the time limit stated in the "Proof of Loss" Section.

Proof of Loss: If the policy provides for periodic payment for a continuing loss, we must be given written proof within 90 days after the end of each period for which we are liable. For any other loss, we must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible.

Time of Payment of Claims: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid at least monthly. When our liability ends, we will pay any remaining balance as soon as we receive written proof of loss.

Payment of Claims: Any loss of life benefit will be paid in accordance with the beneficiary designation on record with us or the **Participating Organization**.

If no beneficiary is named, loss of life benefits will be paid to the first surviving class of the following classes: the **Insured Person's** (1) spouse; (2) child(ren); (3) parents; or (4) brothers or sisters. Otherwise, we will pay benefits to the **Insured Person's** estate.

All other benefits are payable to the **Insured Person**, unless otherwise indicated in the policy. We may pay all or a part of any benefits for health care services directly to the provider, unless the **Insured Person** directs us otherwise, in writing, by the time sufficient written proof of loss is received. We cannot require that the service be given by a certain provider.

If the **Participating Organization** requests, we may (at our option) pay benefits to the **Participating Organization**. The **Participating Organization** will then pay the **Insured Person** or beneficiary entitled to receive the benefits.

Any payment we make in good faith will end our liability to the extent of the payment. **Physical Examination and Autopsy**: We, at our expense, have the right to have the **Insured Person** examined as often as reasonably necessary while a claim is pending. We may also have an autopsy performed unless prohibited by law.

Legal Actions: No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Change of Beneficiary: The **Insured Person** can change the beneficiary at any time by sending a written notice to the **Participating Organization** or us. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Conformity with State Statutes: Any provision of the policy, which, on its effective date, is in conflict with the laws of the state in which the **Insured Person** resides on that date, is amended to conform to the minimum requirements of such laws.

Clerical Error: The insurance of any **Insured Person** will not be affected by a clerical error made by the **Participating Organization** or us. An error will not continue the insurance of an **Insured Person** beyond the date it would end under the policy terms if the error had not been made.

Examination and Audit: We shall be permitted to examine and audit a **Participating Organization's** records relating to the policy at: (1) any reasonable time during the policy term; and (2) within two years after the expiration of the policy or until all claims have been settled or adjusted, whichever is later.

New Entrants: New eligible persons added from time to time to the group of **Insured Persons** originally insured under this plan will be automatically covered under the policy.