Certificate of Insurance

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 8364005 to cover the eligible individuals of:

The Board of Regents of the University of Wisconsin

The insurance evidenced by this **Certificate** provides **ACCIDENT** insurance only. It does not provide **Coverage** for sickness. This **Certificate** describes the main features of the **Policy**, but the **Policy** is the only contract under which benefit payments are made. If there is an inconsistency between the **Certificate** and the **Policy**, the **Policy** will govern.

IMPORTANT NOTICE

THIS INSURANCE PROVIDES ACCIDENT COVERAGE ONLY
THIS INSURANCE DOES NOT PROVIDE BENEFITS FOR SICKNESS

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SECTION I – ELIGIBILITY AND EFFECTIVE DATES

CERTIFICATEHOLDER:

Class I*: All employees eligible for the State of Wisconsin Group Health Insurance Program through the University of Wisconsin.

* **Class I** excludes rehired Wisconsin Retirement System (WRS) annuitants. Rehired annuitants who are receiving a WRS annuity shall be considered, by definition, retirees pursuant to the provisions of **Class II** eligibility.

Class II: All retirees of the **Policyholder**. Retirees may continue coverage in effect, unless excluded, at date of retirement after completing Continuation Form #1249 within sixty (60) days of cessation of insurance. For Covered Employees who retire, coverage may be continued, but not increased, and coverage is subject to the same age reductions of the **Policy** for Covered Employees who are **Active** employees.

Note: If **You** suffer an **Injury** resulting in a **Covered Loss** and **You** are covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF YOUR DEPENDENTS:

Individuals who enroll may elect to cover their eligible **Dependents.** An eligible **Dependent** includes **Your** legally married **Spouse/Domestic Partner** and **Your Dependent Child(ren)**, **Your** legally married **Spouse's Dependent Child(ren)**, and **Your Domestic Partner's Dependent Child(ren)**. A legally married **Spouse/Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your** legally married **Spouse/Domestic Partner**, legally separated **Spouse/Domestic Partner,** former **Spouse/Domestic Partner** are both **Insured's** under the **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

YOUR EFFECTIVE DATE OF INSURANCE:

A. For eligible individuals hired prior to November 1, 2016:
Coverage is effective on the first of the month following the date the eligible employee submits the application to the institution benefits office. If filed on the first day of the month, coverage is effective that day.

B. For eligible individuals hired on or after November 1, 2016:
New Hire/Eligibility Waiting Period: Coverage is effective the first of the month following thirty (30) days of eligible employment, provided an employee elects **coverage** within the first thirty (30) days of being newly eligible for this insurance.

Employees who do not enroll during their new hire eligibility period, **coverage** is effective on the first of the month following the date the eligible employee submits the application to the institution benefits office. If filed on the first day of the month, **coverage** is effective that day.

Employees and **Dependents** must be actively enrolled in the Accidental Death & Dismemberment (AD&D) **coverage** in order to file an insurance claim under this **Policy**.

SECTION II – SCHEDULE

COVERAGE(S):	Classes Covered
24 Hour **Accident** Protection, Business and Pleasure, Including Corporate Owned or Leased Aircraft, Passenger and Crew, H-1	All
Specified Pilot Coverage	All
Exposure and Disappearance Coverage	All
Reserve Corps/National Guard Unit Coverage	All

BENEFITS:	Classes Covered
ACCIDENTAL DEATH BENEFIT	All

Principal Sum:

Class I: **You** may select one of the following **Principal Sum** amounts: $25,000; $50,000; $100,000; $150,000; $200,000; $250,000; $300,000; $350,000; $400,000; $450,000; or $500,000.

Class II: As a Retiree, **You** must continue with **Your** prior selected **Principal Sum** amount when **You** were an employee or a lesser **Principal Sum** amount: $25,000; $50,000; $100,000; $150,000; $200,000; $250,000; $300,000; $350,000; $400,000; $450,000; or $500,000.

The **Principal Sum** for **Your Covered Dependents** will be a percentage of **Your Principal Sum**, as follows:

Plan Selected	% Spouse/Domestic Partner	% Child(ren)
Spouse/Domestic Partner only:	60%	0
Dependent Child(ren) only:	0	20%
Spouse/Domestic Partner and **Dependent Child(ren):**	50%	15%

Maximum of $300,000 **Principal Sum** for **Your Spouse/Domestic Partner**.
Maximum of $50,000 **Principal Sum** for **Your Dependent Child(ren)**.

At age 70, for **You** and **Your Covered Spouse/Domestic Partner** only, the **Principal Sum** will be reduced based on the **Covered Person's** previous **Principal Sum** per the following schedule:

Age at Date of Loss	Percent of Principal Sum
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

This schedule of reduced benefits applies to the **Accidental Death Benefit** and the **Accidental Dismemberment and Covered Loss of Use Benefit.**

	Classes Covered
ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT	All
Principal Sum:	
Same as above.	
Coma Benefit	All
Permanent and Total Disability Benefit	Class I

ADDITIONAL BENEFITS:	**Classes Covered**
Additional Dismemberment Benefit for Children	All
Carjacking Benefit	All
Continuation of Insurance Benefit	All
Critical Burn Benefit	All
Day Care Benefit	All
Hearing Aid or Prosthetic Appliance Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Natural Disaster Benefit	All
Rehabilitation Benefit	All
Seat Belt/Air Bag Benefit	All
Spouse/Domestic Partner Retraining Benefit	All
Surviving Spouse/Domestic Partner Benefit	All
Therapeutic Counseling Benefit	All
Travel Assistance Plan	All

ADDITIONAL ENDORSEMENTS	Form Number	Classes Covered
Safety Device Benefit	U-VA-113-A (CW) (02/09)	All
Amendment to Dependent Children and Domestic Partner Definitions	U-VA-104-A (CW) (09/06)	All
Amendment to Payment of Claims	U-VA-104-A (CW) (09/06)	All

SECTION III – DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

Active and **Actively at Work** describes **You** if **You** are able and available for active performance of all of **Your** regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided **You** are able and available for active performance of all of **Your** regular duties and were working the day immediately prior to the date of **Your** absence.

Aggregate Limit of Liability means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the **Aggregate Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the **Aggregate Limit of Liability** is not enough to pay full benefits to each **Covered Person**, **We** will pay each one a reduced benefit based upon the proportion that the **Aggregate Limit of Liability** bears to the total benefits which would otherwise be paid.

Certificate means this **Certificate** for the **Group Accident Insurance Policy.**

Chartered Aircraft means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.

Controlled by, as used in the **Coverages** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

Coverage(s) means the event or events described in the **Hazards** of the **Policy** to which benefits and additional benefits apply. The **Hazards** are listed in the **Coverages** Section on the Schedule.

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Injury means an **Injury** directly caused by accidental means, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under the **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under the **Policy**.

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You** and **Your Spouse/-Domestic Partner** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)**.

Dependent means **Your Spouse**/**Domestic Partner** and **Dependent Child(ren),** as defined in this section. The **Dependent** will only be a **Covered Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren) means **You** or **Your Domestic Partner's** unmarried **child(ren),** including natural child, stepchild, adopted child, legal ward and a child in an adoptive placement under Wis. Stats. §43.837(1) and §48.833(2), who is dependent upon the employee for at least 50% of support and maintenance and who are:

> **Dependent Child(ren)** who are more than fourteen (14) days old, counting from birth, but under nineteen (19) years of age.
>
> **Dependent Child(ren)** who become married are eligible to the end of the month in which they became married.

Dependent Child(ren) who attain the age of 19 and are not enrolled on a full-time basis in a college, university or trade school are eligible to the end of the calendar year in which they attain the age of nineteen.

Dependent Child(ren) who are less than twenty five years of age and no longer enrolled on a full-time basis in a college, university or trade school are eligible to the end of the calendar year in which they cease to be enrolled in a college, university or trade school.

Dependent Child(ren) who are enrolled on a full-time basis in a college, university or trade school and attain the age of twenty-five are eligible to the end of the calendar year in which they attain the age of twenty-five. (U-VA-104-A (CW) (09/06))

Domestic Partner means a person with whom the **Insured** employee is in a domestic partnership and **You** and **Your Domestic Partner** have submitted a University of Wisconsin System (UWS) Affidavit of Domestic Partnership (UWS 50) to the University of Wisconsin.

In order to enroll a **Domestic Partner** in the coverage, **You** must submit the UWS Affidavit of Domestic Partnership. (U-VA-104-A (CW) (09/06))

Injury means a bodily **Injury**.

Insured means an individual who is eligible for **Coverage** under the **Policy** as provided in the Certificateholder part of the **Eligibility and Classification of Insureds** Section, and who completes the enrollment material, if required.

Owned Aircraft means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.

Plan means the **Plan** design as described on the **Schedule**.

Policy means the Group **Accident** Insurance **Policy**.

Policyholder means the group named on the front page of the **Policy**.

Specialized Aviation Activity means an aircraft while it is being used for one or more of the following activities:

- acrobatic or stunt flying
- aerial photography
- banner towing
- bird or fowl herding
- crop dusting
- crop seeding
- crop spraying
- endurance tests
- exploration
- fire fighting
- flight on a rocket-propelled or rocket launched aircraft
- flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted
- hang gliding
- hunting
- parachuting or skydiving
- pipe line inspection
- power line inspection
- racing
- skywriting
- test or experimental purpose

Spouse, if used in the **Policy,** means **Your** legally married **Spouse**.

Under lease, as used in the **Coverages** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

We, Us, and **Our** refers to Zurich American Insurance Company.

You, **Your** refers to the **Insured**.

SECTION IV – COVERAGES

24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE INCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, PASSENGER ONLY, H-1

The **Hazards** insured against by the **Policy** are:

A **Covered Injury** sustained by a **Covered Person** anywhere in the world, subject to the terms, conditions, exclusions and limitations under the **Policy**.

Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Covered Person** is a passenger, riding in or on, boarding or getting off:

A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

- **1.** medical certificate; and
- **2.** pilot certificate with a proper rating to pilot such aircraft

B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft. Or

B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

- **1.** any aircraft other than those expressly stated in this **Coverage**;
- **2.** any aircraft except the following aircraft:

  Aircraft on file with the **Policyholder**

  provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least N/A hours of which at least N/A hours were logged in this or the same class of aircraft.
- **3.** any aircraft engaged in a **Specialized Aviation Activity**;
- **4.** any conveyance used for tests or experimental purposes, or in a race or speed test.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

SPECIFIED PILOT COVERAGE

The Hazard Exclusion in **24 Hour Accident Protection, Business and Pleasure Including Corporate Owned or Leased Aircraft, Passenger Only, H-1**, stating that **" Coverage** is not provided if the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of a covered aircraft." is modified to provide **Coverage** for the following named pilot(s) only:

All pilots

while piloting the following aircraft:

All Aircraft

provided such aircraft has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor, and the above named pilot(s) has a current and valid medical certificate and pilot certificate with a proper rating to fly such aircraft.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

EXPOSURE AND DISAPPEARANCE COVERAGE

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the **Covered Person** lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

RESERVE CORPS/NATIONAL GUARD UNIT COVERAGE

If **You** suffer an **Injury,** resulting in a **Covered Loss**, as defined under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit,** while **You** are a member of an organized **Reserve Corps** or **National Guard Unit** and as such, **You** are:

1. attending any regularly scheduled or routine training of less than thirty (30) days, or **You** are enroute to or from such training;
2. attending a **Service School** or **You** are enroute to or from such **Service School**;
3. taking part in any authorized inactive duty training; or,
4. taking part as a unit member in a parade or exhibition authorized by official orders.

You will be eligible to receive the applicable **Principal Sum** for such **Covered Loss**.

No benefit will be payable for any loss that occurs during active duty.

For purposes of this **Coverage**, **Service School** means one operated by, or on behalf of, the United States of America or Canada.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII General Limitations.

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

If an **Injury** to a **Covered Person** results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	**Benefit**
1. Both Hands or Both Feet	**Principal Sum**
2. One Hand and One Foot	**Principal Sum**
3. One Hand or One Foot plus the loss of Sight of One Eye	**Principal Sum**
4. Sight of Both Eyes	**Principal Sum**
5. Speech and Hearing	**Principal Sum**
6. Speech or Hearing	50% of **Principal Sum**
7. One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
8. Thumb and Index Finger of the same Hand	25% of **Principal Sum**

Covered Loss of Use of	**Benefit**
1. Four **Limbs**	150% of **Principal Sum**
2. Three **Limbs**	75% of **Principal Sum**
3. Two **Limbs**	66 2/3% of **Principal Sum**
4. One **Limb**	50% of **Principal Sum**

For purposes of this benefit:

1. **Covered Loss** means:
   - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
   - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
   - **c.** Total and permanent loss of sight;
   - **d.** Total and permanent loss of speech;
   - **e.** Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

COMA BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** will be payable at 1% of the **Covered Person's Principal Sum** per month for the first 12 months the **Covered Person** remains in a **Coma**, following the initial thirty-one (31) day period. At the end of the 12 months of payment, if the **Covered Person** remains in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the **Accidental Death Benefit** less the amount of the 12 months of benefit already received.

Coma will be determined by **Our** duly licensed physician.

This benefit is subject to the limitations in Section VIII General Limitations.

PERMANENT AND TOTAL DISABILITY BENEFIT

Class I Only:

If **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury We** will pay a **Permanent and Total Disability Benefit** provided that **You** become **Permanently and Totally Disabled** within 180 days of the **Injury**; and the **Permanent and Total Disability** continues for twelve (12) months. The benefit payable equals **Your Principal Sum** less any amount payable pursuant to the limitations in Section VIII – General Limitations of the **Policy**.

For purposes of this benefit**, Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that **You** are reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the rest of **Your** life.

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If **You** selected a **Plan** covering **Your** eligible **Dependent Child(ren),** and a **Covered Dependent Child** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment Benefit, We** will pay **You** an additional benefit which will be equal to the benefit amount provided by the **Accidental Dismemberment Benefit.**

CARJACKING BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the **Covered Person** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to 10% of the applicable **Principal Sum** to a maximum of $25,000.

Verification of the **Carjacking** must be made part of an official police report within twenty-four (24) hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24)hours or as soon as reasonably possible and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than the **Covered Person** taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

CONTINUATION OF INSURANCE BENEFIT

If **You**, selected a **Plan** covering **Your Dependents** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, all **Coverages** under the **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than **You**, will be continued automatically for 365days after the date of the loss at no additional cost.

CRITICAL BURN BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** as a result of a **Covered Accident** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit,** an additional benefit will be payable equal to the lesser of 10% of the applicable **Principal Sum** or $25,000, provided all terms and conditions of the **Policy** are met and:

1. the **Covered Person** has received second degree or higher burns over 25% of his or her body; and
2. the **Covered Person** has undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within 365 days of the occurrence of the **Injury**.

DAY CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse/Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 3% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. $5,000.

If both **You** and **Your Covered Spouse/Domestic Partner** suffer a simultaneous **Covered Loss**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Covered Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Covered Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

HEARING AID OR PROSTHETIC APPLIANCE BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit provided:

1. the **Covered Person** is required to use a hearing aid or prosthetic appliance;
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Covered Loss of Use Benefit** is the same **Injury** that requires the **Covered Person** to use the **Hearing Aid or Prosthetic Appliance**; and
3. the **Hearing Aid or Prosthetic Appliance** was required within one (1) year of the **Injury**.

The amount **We** will pay will be equal to the one time cost of the **Hearing Aid or Prosthetic Appliance** actually paid by the **Covered Person**.

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified physician or surgeon who is not the **Covered Person's** spouse, child, or relative; and

2. presentation of proof of payment is provided to **Us**.

For purposes of this benefit, **Prosthetic Appliance** will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Covered Person's Principal Sum** or $15,000.

HIGHER EDUCATION BENEFIT

If **You** selected a **Plan** covering **Your Dependent Child(ren)** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Covered Dependent Child**.

A **Covered Dependent Child** is eligible for the **Higher Education** benefit if on the date of the **Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education** will be equal to 10% of **Your Principal Sum**, to a maximum of $25,000 per year. This amount will be paid annually for four (4) consecutive years if **Your Covered Dependent Child** continues his or her education. Before this benefit is paid each year, **Your Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no **Covered Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of $1,000 to the designated beneficiary.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the **Covered Person** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Covered Loss of Use Benefit** is the same **Injury** that requires the **Covered Person** to need the wheelchair.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to the **Covered Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Covered Person's Principal Sum** or $50,000.

NATURAL DISASTER BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a direct result of a **Natural Disaster**, **We** will pay an additional benefit equal to the lesser of 10% of the **Covered Person's Principal Sum** or $50,000.

For purposes of this benefit, **Natural Disaster** means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event.

REHABILITATION BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training** in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. $15,000; or
3. 10% of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation which **You** would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

SEAT BELT/AIR BAG BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay to the beneficiary an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of $25,000, provided that the **Covered Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

An additional benefit equal to 10% of the **Covered Person's Principal Sum** to a maximum of $25,000, will be paid if the **Covered Person** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt** or **Air Bag Benefit** if the driver of the private passenger automobile in which the **Covered Person** was riding was either:

1. under the voluntary influence of alcohol;
   - **a.** A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the voluntary influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT

If **You** selected a **Plan** covering **Your Spouse/Domestic Partner** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay to, or on behalf of, **Your Covered Spouse/Domestic Partner**, the actual cost of any professional or trade-training program in which the **Covered Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from **Your** death.

The maximum amount payment under this benefit will be the lesser of 5% of **Your Principal Sum** or $25,000.

SURVIVING SPOUSE/DOMESTIC PARTNER BENEFIT

If **You** selected a **Plan** covering **Your Spouse/Domestic Partner** and **You** suffer an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit to **Your Covered Spouse/Domestic Partner**. The monthly benefit will be equal to 1% of **Your Principal Sum** and will be paid for a period of twelve (12) months.

THERAPEUTIC COUNSELING BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Dependents** suffer an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit,** and **You** or **Your Covered Dependents** require **Therapeutic Counseling**, **We** will reimburse the actual expense for such counseling to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;
3. **Therapeutic Counseling** must be incurred within one (1) year from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $2,500 for any one **Covered Accident**.

TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse/Domestic Partner** and/or **Child(ren),** if covered under the **Policy.** The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by **Us**. Under the **Policy,** the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation

  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which based upon **Our** evaluation cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

  For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

  Medical Repatriation

  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to his or her **Principal Residence** or to his or her residence in the country where he or she is currently assigned (at his or her option) in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable which is also subject to the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

Return of Remains

If a **Covered Person** dies while on a **Covered Trip, We** will pay and make arrangements for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

Visit to Hospital

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

Return of Child

If a **Covered Person** is traveling with a **Child** who is under nineteen (19) years of age or a **Child** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion

If a **Covered Person** is traveling with a companion while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one way economy class flight, whichever is less. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide the **Travel Assistance Plan** if the **Coverage** is excluded under Section VII – General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the voluntary influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a MEDICAL EVACUATION, the medical care which is being provided is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or MEDICAL REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this coverage. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of this **Travel Assistance Plan** only, the following definitions apply:

  "Covered Trip" means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set above.

  "Illness" or **"Ill"** means a sickness or disease which impairs normal functions of the body.

  "Injured" "Injury" or **"Injuries"** means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

  "Principal Residence" means the legal domicile of the **Covered Person** in his or her country of citizenship.

  "Western Medical Standards" means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

  For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the **Policy,** the definition in the **Travel Assistance Plan** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  Right of Recovery

  We have the right to recover any benefits which **We** have paid under this **Travel Assistance Plan** if the **Policyholder** or **Covered Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Covered Person** which were covered under this **Travel Assistance Plan. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Covered Person** for transportation services and/or expenses, which were not covered under the **Travel Assistance Plan.**

  Reservation of Rights

  We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

  Scope

  Illness, as covered under the **Travel Assistance Plan,** is solely covered under the **Travel Assistance Plan,** and in no way supersedes or modifies the other benefits provided under the **Policy**.

To contact **Us** regarding the **Travel Assistance Plan**, the **Covered Person** must call 1-800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

SECTION VII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service. Reserve or National Guard see **Certificate SECTION IV – COVERAGES;**
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. commission or attempt to commit a felony, or that occurs while engaged in an illegal occupation;
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous-activity;
7. being voluntarily intoxicated.
   - **a.** A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.

8. being under the voluntary influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
9. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

SECTION VIII – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If a **Covered Person** suffers more than one loss as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Benefits. If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit**, **Coma Benefit, Permanent and Total Disability Benefit** as a result of the same **Accident,** the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

Limitation on Multiple Hazards. If a **Covered Person** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit.

SECTION IX - TERMINATION OF INSURANCE

Your Insurance**. Your** insurance terminates at the end of the month and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written Policy, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of **Coverage** is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.

Your Covered Dependent's Insurance. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after **Your Covered Dependent** no longer qualifies as a **Covered Person**.

Conversion Privilege

If **Your** insurance ceases for reasons other than termination of the **Policy** or nonpayment of premium, **You** are entitled to convert **Your Coverage** to an **Individual Accidental Death or Dismemberment** (**IAD)** policy or to a **Family AD&D** (**FAD)** policy if **You** selected a **Plan** covering **Your Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. **You** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of **Your** insurance under the Group **Accident Policy**. To request a Conversion Application Form, **You** must call 1-800-834-1959. **You** do not have to show proof of good health.

The issuance of the **IAD** or **FAD** policy is subject to the following conditions:

1. The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or $250,000;
2. The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and
4. When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

The **Conversion Privilege** will cease when **You** attain age 70.

SECTION X - HOW TO FILE A CLAIM

A. Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

B. Claim Forms. **We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and extent of **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

C. Proof of Covered Loss. Written proof of **Covered Loss** must be given to the **Company** within ninety (90) days after the date of loss. If the proof of loss is not submitted within ninety (90) days, the claim may be reduced or invalidated. The claim will not be reduced or invalidated if:

1. it can be shown that it was not possible within reason to submit notice within the ninety (90) day period; and
2. it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

SECTION XI - PAYMENT OF CLAIMS

A. Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

B. Who We Will Pay.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:

- **a.** **Your** legally married **Spouse** or **Domestic Partner**;
- **b.** **Your Child(ren)**;
- **c.** **Your** parents;
- **d.** **Your** brothers and sisters;
- **e.** **Your** estate.
  (U-VA-104-A (CW) (09/06))

2. Loss of Life of **Your Covered Dependent**. **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.

3. All Other Claims. Benefits are to be paid to the **Covered Person**.

C. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

D. Choice of Service Provider. The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

SECTION XII - GENERAL POLICY CONDITIONS

A. Beneficiaries. **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us.**

B. Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

C. Clerical Error. A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

D. **Conformity with Statute.** Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

E. **Suit Against Us.** No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

F. **Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

In Witness Whereof, **We** have caused this **Policy** to be executed and attested, and, if required by state law, this **Policy** will not be valid unless countersigned by **Our** authorized representative.

Mark E. Knipfer
President
Zurich American Insurance Company

Dennis Kerrigan
Corporate Secretary
Zurich American Insurance Company

NON-PARTICIPATING

The Board of Regents of the University of Wisconsin
GTU 8364005
Effective: January 1, 2019

Version: January 2019

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

This endorsement, effective November 1, 2015, forms a part of **Policy** No. GTU 8364005, issued to The Board of Regents of the University of Wisconsin.

THIS ENDORSEMENT CHANGES THE CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Group Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Certificate:**

SECTION II – SCHEDULE is amended to include the following:

ADDITIONAL BENEFITS:	**Classes Covered**
Safety Device Benefit	ALL

SECTION VI – ADDITIONAL BENEFITS is amended to include the following:

SAFETY DEVICE BENEFIT

If **You** or **Your Dependent** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the **Accidental** death directly resulted from an **Accident**, **We** will pay an additional benefit, which equals 10% of the **Insured's Principal Sum** up to a maximum of $25,000, provided that the **You** or **Your Dependent** was:

1. operating or riding as a passenger in or on any private passenger automobile, motorcycle, scooter, moped, bicycle, boat or seagoing vessel, sailboard, personal watercraft, all-terrain vehicle, all-terrain cycle, snowmobile or while participating in downhill skiing, snowboarding, horseback riding, water skiing or other towed activities; and
2. wearing or protected by, as per manufacturer's instructions, any of the following:
   a. an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.
   b. a manufacturer equipped air bag, provided the **Your** or **Your Dependent's** seat belt or lap and shoulder restraint was fastened at the time of the **Accident**.
   c. an **Approved Personal Flotation Device** while **You** or **Your Dependent** are swimming, engaging in water sports or legally operating or riding as a passenger in a boat, seagoing vessel, sailboard or personal watercraft.
   d. an **Approved Motorcycle Helmet** while **You** or **Your Dependent** are operating or riding as a passenger on a motorcycle, scooter, moped, all-terrain vehicle (ATV), or all-terrain cycle (ATC) that is being operated legally per all local and state laws, rules and regulations.
   e. an **Approved Snowmobile Helmet** while **You** or **Your Dependent** are operating or riding as a passenger on a snowmobile that is being operated legally.
   f. an **Approved Bicycle Helmet**, while **You** or **Your Dependent** are legally operating a bicycle.
   g. an **Approved Ski Helmet** while **You** or **Your Dependent** are engaged in downhill skiing or snowboarding, after purchasing a valid lift ticket and skiing/snowboarding during normal operating hours and on the marked premises of the facility selling the lift ticket.
   h. an **Approved Equestrian Helmet** while **You** or **Your Dependent** are engaged in horseback riding.
   i. an **Approved Protective Helmet** while **You** or **Your Dependent** are actively at work.
   j. **Approved Body Armor** while **You** or **Your Dependent** are actively at work.

Verification of the **You** or **Your Dependent's** actual use of the Safety Device is required as follows:

1. by supplying the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

We will not pay a **Safety Device Benefit** if **You** or **Your Dependent** was the driver or operator of any private passenger automobile, motorcycle, scooter, moped, bicycle, boat or seagoing vessel, sailboard, personal watercraft, all-terrain vehicle, all-terrain cycle, snowmobile or while participating in downhill skiing, snowboarding, horseback riding, water skiing or other towed activities, if at the time **You** or **Your Dependent** were:

1. under the influence of alcohol:
   a. a driver/operator will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle.
   b. an autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage; or
3. engaged in contests or competitions.

SAFETY DEVICE BENEFIT DEFINITIONS:

Approved Personal Flotation Device (PFD) means a United States Coast Guard approved Type I, II, III or V PFD of appropriate size for the intended user. For water skiing, other towed activities or operation of a personal watercraft a PFD labeled for that activity must be used.

Approved Motorcycle Helmet means a helmet meeting United States Department of Transportation Federal Motor Vehicle Safety Standard (FMVSS) 218 or subsequent standard(s).

Approved Snowmobile Helmet means a helmet meeting the United States Department of Transportation FMVSS 218 or subsequent standard(s).

Approved Bicycle Helmet means a helmet meeting American Society of Testing and Materials (ASTM) standard F1447 or subsequent standard(s).

Approved Ski Helmet means a helmet conforming to Snell Memorial Foundation standards S-98 or RS-98 or ASTM standard F2040 or subsequent standard(s).

Approved Equestrian Helmet means a helmet conforming to Snell Memorial Foundation standard E-2001 or ASTM standard F1163 or subsequent standard(s).

Approved Protective Helmet means a helmet complying with American National Standards Institute (ANSI) standard Z89.1-2003 or subsequent standard(s).

Except for the above, this Amendatory Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. 1

Signed for by Zurich American Insurance Company Mark G. Kaupfer Date: November 1, 2015

Notice to Wisconsin Policyholders/ Certificateholders

ZURICH

<u>KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS</u>

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problems.

Zurich North America
Customer Inquiry Center
1299 Zurich Way
Schaumburg, Illinois 60196-1056
1-800-382-2150

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

SANCTIONS EXCLUSION ENDORSEMENT

ZURICH

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED

Privacy Notice

We Take Important Steps to Protect the Personal Information We Collect About You

Dear Customer: ***rev. October 2016***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information we collect about you and what we do with that information. This Privacy Notice describes the nonpublic personal information we collect about you and how we handle the information as it relates to individuals who either own or are covered by insurance we issue, or who use other financial products or services we provide.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
Why are you receiving this Notice?	Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company.
What types of Information do we collect?	The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include: • Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information; • Information about your transactions with the Company and its affiliates; • Information about your claims history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property; and • Information we receive from a consumer reporting agency, such as a credit report. When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.
What do we do with the nonpublic personal information we collect?	WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING).

Reasons we may share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
For our everyday business purposes – to affiliates and non-affiliates to process your transactions, administer insurance coverage, products or services, maintain your account and report to credit bureaus	Yes	No
For our marketing purposes or for joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – creditworthiness	No	No
For our affiliates to market to you	Yes	No
For non-affiliates to market to you	No	We don't share

Collecting and safeguarding information	
How often does the Company notify me about their practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision.
Why and how does the Company collect my nonpublic personal information?	We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from: • Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income. • Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc. • Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What nonpublic personal information does the Company disclose?	We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?".

How does the Company safeguard my nonpublic personal information?	Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once in writing, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW

Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: • Processing transactions, mailing and auditing services • Administering insurance coverage, product, services or claims • Providing information to credit bureaus • Protecting against fraud • Responding to court/governmental orders or subpoenas and legal investigations • Responding to insurance regulatory authorities
Affiliates	Financial or nonfinancial companies related by common ownership or control. • *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.*

Non-affiliates	Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services. • *Company does not share information with non-affiliates to market to you*.
Joint marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you. • *Company does not jointly market.*

Changes to this Privacy Notice; contact us	We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes. If you have any questions about your contract with us, you should contact your agent. If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

This Privacy Notice is sent on behalf of the following affiliated companies:

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company").