

Berkley Life and Health Insurance Company

Urbandale, Iowa

Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690

A Berkley Company

866.723.4452

Blanket Accident Policy

Policyholder: Hackensack Junior Soccer Association c/o The Berkley LH&A Insurance Program Trust

Policy Number: PAI L01400273 001

Effective Date: 4/15/2016

This Policy is a legal contract between the Policyholder and [Berkley Life and Health Insurance Company](#) (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state where it was delivered.

Signed for the Company:



President



Secretary

**THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
THIS IS A LIMITED POLICY.
PLEASE READ THE POLICY CAREFULLY.**

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SCHEDULE OF BENEFITS

POLICYHOLDER: Hackensack Junior Soccer Association c/o The Berkley LH&A Insurance Program Trust

POLICY EFFECTIVE DATE: 4/15/2016

POLICY NUMBER: PAI L01400273 001

PREMIUM DUE DATE: Annual in advance

POLICY PERIOD: 4/15/2016 to 4/15/2017

CLASSES OF ELIGIBLE PERSONS:

Class 1 Enrolled participants of the Policyholder.

PREMIUMS - \$ 772.00

AGGREGATE LIMIT OF LIABILITY:

Benefit Maximum	\$ 250,000
Applies During	per Covered Accident.
Applies To	Accidental Death & Dismemberment Benefits only

HAZARDS INSURED AGAINST:

<u>Class</u>	<u>Description of Hazard</u>
Class 1	Supervised and Sponsored Activities

Covered Activity(ies): Supervised and Sponsored Activities of the Policyholder, including travel directly and without interruption, to and from the Covered Person's home and the site of the activity. Policyholder sponsored domestic travel is also included.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum:	\$ 10,000
Time Period for Loss:	365 days

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Total Benefit Maximum for all Accident Medical:	\$ 50,000
Loss Period (first Covered Expenses must be incurred within):	90 days after the Covered Accident
Benefit Period:	52 Weeks
Deductible:	\$ 250
Benefit Percentage:	100%
Terms of Payment:	Full Excess
Dental Benefits:	100% of Accident Medical Benefit

Accident Medical Expense benefits may be available on an allocated or unallocated basis as shown, that is to say there may be specific limits or coinsurance rates on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and coinsurance factor (unallocated).

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy and indicated on the Schedule of Covered Losses.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

DEDUCTIBLE means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident before Accident Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under this Policy. Only one Deductible will apply to the Covered Person and his or her Dependents if Injured in the same Covered Accident.

HOSPITAL means an institution that:

- 1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) provides 24-hour nursing service by registered nurses on duty or call;
- 3) has a staff of one or more licensed Physicians available at all times;
- 4) provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 6) is not a place for drug addicts, alcoholics or the aged.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL STAY means a confinement of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

IMMEDIATE FAMILY means the Covered Person's parent, grandparent, spouse, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws.

INJURY means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICALLY NECESSARY means a treatment, service or supply that is:

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

PHYSICIAN means a person who is a qualified practitioner of the healing arts, including a chiropractor and a dental practitioner. As such, He or She must be acting within the scope of his/her license under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's spouse, son, daughter, father, mother, brother or sister or other relative.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means [Berkley Life and Health Insurance Company](#) underwriting this insurance.

YOU, YOUR, YOURS, HE or SHE means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the Classes of Eligible Persons shown on the Policy Schedule of Benefits, He or She is eligible to be covered on the Policy Effective Date. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:

- 1) the Policy Effective Date; or
- 2) the date such person becomes eligible, subject to any required waiting period, as described in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:

- 1) The Policy Termination Date shown in this Policy; or
- 2) The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under this Policy ends on the earliest of:

- 1) The date this Policy terminates;
- 2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid; or
- 4) The last day of the period for which premiums have been paid.

PREMIUMS

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium is due on the Policy Effective Date. After that, premium will be due monthly unless otherwise stated in the Policy.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date, except as provided under the Grace Period section.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in any federal or state law or regulation affecting this Policy and Our benefit obligation.
- 4) A change in the factors bearing on the risk assumed.
- 5) A misrepresentation in the information relied on in establishing the rate for this Policy.

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

Grace Period

After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided the Policyholder pays all the premiums due by the last day of the grace period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the grace period.

HAZARDS INSURED AGAINST

We will pay benefits described in this Policy when a Covered Person suffers a Covered Loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

SUPERVISED AND SPONSORED ACTIVITIES

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) attending or participating in a Supervised and Sponsored Activity; or
- (2) attending a Policyholder function, as described on the Schedule of Benefits.

The Covered Person must be:

- (1) on the premises of the Policyholder:
 - (a) during its normal hours;
 - (b) during scheduled functions; and
 - (c) during other periods if He is attending or participating in a Supervised and Sponsored Activity.
- (2) not on Policyholder premises and attending or participating in a Supervised and Sponsored Activity;
- (3) Travel as part of group in transportation authorized or arranged by the policyholder; or,
- (4) Traveling directly, without interruption:
 - (a) between his home and the premises of the policyholder or the site of the Supervised and Sponsored Activity. Such travel must be in a vehicle operated by a licensed driver. Such travel time cannot exceed an hour each way.

“Supervised and Sponsored Activity” means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.

DESCRIPTION OF BENEFITS

All benefits payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Time Period for Loss as shown in Schedule of Benefits, the Company will pay the percentage of the Principal Sum shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit, the largest, will be paid for all Covered Losses due to the same Covered Accident.

Schedule of Covered Losses

Loss of:

Benefit:

(Percentage of Principal Sum)

Life	100%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Uniplegia	25%
Thumb and Index Finger of the Same Hand	25%
Four fingers of the Same Hand	25%

“Member” means Loss of Hand or Foot, Loss of Arm or Leg, Loss of Sight, Loss of Speech and Loss of Hearing. “Loss of a hand or foot” means complete severance through or above the wrist or ankle joint. “Loss of Arm or Leg” means complete Severance through or above the elbow or knee joint. “Loss of sight” means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. “Loss of speech” means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. “Loss of hearing” means permanent total deafness in both ears such that it cannot be corrected by any aid or device. “Loss of thumb and index finger of the same hand” means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

“Hemiplegia” means total Paralysis of the upper and lower limbs on one side of the body.

“Paraplegia” means total Paralysis of both lower limbs or both upper limbs.

“Quadriplegia” means total Paralysis of both upper and lower limbs.

“Uniplegia” means total Paralysis of one lower limb or one upper limb.

Aggregate Limit of Liability

The maximum amount the Company will pay for all Covered Losses resulting from the same Accident will not exceed the Aggregate Limit of Liability as described in the Schedule of Benefits.

If the total amount payable for all Covered Losses in any one Accident exceeds the Aggregate Limit of Liability, each Covered Person’s Covered Loss will be paid at the same ratio that the Aggregate Limit of Liability has to the total amount of all Covered Losses. The Company shall not be liable for amounts in excess of the Aggregate Limit of Liability.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Co-payments, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
- 3) for Covered Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses, from a Covered Accident, include:

- 1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
- 2) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
- 3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
- 5) Outpatient surgery expenses, including Ambulatory Surgical Center.
- 6) Outpatient surgical room and supply expenses for use of the surgical facility.
- 7) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 8) Physician non-surgical treatment/examination expenses (excluding medicines) including the Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.
- 9) Second surgical opinion expenses.
- 10) Physician surgical expenses. If an Injury requires multiple surgical procedures, we will pay 100% of the available benefit for the largest of the procedures performed, 50% of the available benefit for the second procedure and 25% of the available benefit for any additional eligible procedures.
- 11) Assistant Surgeon expenses when Medically Necessary.
- 12) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 13) Outpatient laboratory test expenses.
- 14) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 15) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 16) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 17) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Covered Accident.
- 18) Outpatient registered nurse services if ordered by a Physician.
- 19) Ambulance expenses for transportation from the Accident site to the Hospital.
- 20) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
- 21) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 22) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.

- 23) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 24) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

Terms of Payment for Accident Medical and Dental Expense Benefit

Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable and sub-limits under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions and/ or failure to utilize the network providers and facilities of His primary coverage will result in a benefit reduction of Covered Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- (1) group or blanket insurance, whether on an insured or self-funded basis;
- (2) hospital or medical service organizations on a group basis;
- (3) Health Maintenance Organizations on a group basis;
- (4) group labor management plans;
- (5) employee benefit organization plan;
- (6) professional association plans on a group basis;
- (7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- (8) automobile no-fault coverage (unless prohibited by law).

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an accidental bodily Injury, unless otherwise covered under this policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Disease or disorder of the body or mind.
6. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
7. Intoxication or being under the influence of any drug or narcotic.
8. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
9. Conditions that are not caused by a Covered Accident.
10. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.

11. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
12. Travel or activity outside the United States.
13. Participation in any motorized race or speed contest.
14. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
15. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
16. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
17. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
18. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
19. Mental or nervous disorders, except as specifically provided in this policy.
20. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
21. Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.
22. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in the Policy.
23. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
24. Loss resulting from participation in any activity not specifically covered by this Policy.
25. Any treatment, service or supply not specifically covered by this Policy.
26. Eyeglasses, contact lenses, hearing aids.
27. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - ii. While being used for any test or experimental purpose; or
 - iii. While piloting, operating, learning to operate or serving as a member of the crew thereof.
28. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
29. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
30. Treatment of a hernia whether or not caused by a Covered Accident.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at AG Administrators, P.O. Box 979, Valley Forge, PA 19482, Attn: Claims Department. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, 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 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 180 days after the date of loss. If the proof of loss is not submitted within 180 day, the claim may be reduced or invalidated. However, 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 180 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.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'.

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error or
- 2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

RIGHT OF RECOVERY: A Covered Person may incur charges due to an Injury for which benefits are paid by this Policy. The Injury may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made, the Covered Person must repay Us the Recovery made from 1) the other person; or 2) the other person's insurer.

Only the amount recovered for charges incurred will be subject to Refund. One-third of the Net Recovery will be deemed to be for such charges. However, in no case will the amount of Refund exceed the amount of benefits paid for the Injury under this Policy.

The right of Refund also applies when the Covered Person recovers under an uninsured or underinsured motorist plan.

"Recovery" means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

"Net Recovery" means the Covered Person's Recovery less attorney's fees and court costs incurred in making the Recovery.

"Refund" means repayment to Us for benefits paid.

SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's Subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT/CHANGES: This Policy and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company.

Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy in conflict on its effective date with the laws of the State of Issue indicated on the front page of this Policy is amended to conform to the minimum requirements of such laws.

DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner;
 - b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
 - c) a Covered Person's parents, whether natural, step or adoptive; otherwise.
- 4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.

ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under this Policy.

LEGAL ACTION: All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, Deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, Deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

WORKERS' COMPENSATION: This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

New Jersey Guaranty Notice

Section 17B:32A-17b of the New Jersey Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the New Jersey Life and Health Insurance Guaranty Association Act.

Any questions concerning this summary should be directed to the New Jersey Life and Health Insurance Guaranty Association or to the New Jersey Insurance Department at the addresses contained in the summary.

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
7th Floor
Newark, NJ 07102**

**State of New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625**

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the New Jersey Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than \$500,000 in life insurance death benefits and present value annuity benefits, including new cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than \$100,000 in cash surrender values for life insurance, \$100,000 in cash surrender values for annuity benefits, \$500,000 in life insurance death benefits or \$500,000 in present value of annuities - again, no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than \$2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are not limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.