UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way • 3rd Floor • Eatontown, NJ 07724

GROUP APPLICATION

This is an application for ACCIDENT **ONLY INSURANCE** on form GA26932. It is based on the following statements, and representations.

GROUP POLICY NO: US095867 ■ NEW ☐ REVISION

1. POLICYHOLDER: North American Boxing Federation

Address: P.O. Box 600183; Dallas, TX 75360-0183

Type of business or organization: Association

Coverage for subsidiaries: ■ No ☐ Yes; attach list.

Persons who qualify within the Plans and classes described below are eligible to be insured under the Policy.

2. REQUESTED EFFECTIVE DATE: 5/1/2013

3. BASE PLAN

A. Class **DESCRIPTION** **Number Eligible**

I. All Participants of Policyholder for Boxing - 5 and under Bouts.

II. All Participants of Policyholder for Boxing - 6-10 Bouts.

III. All Participants of Policyholder for Mixed Martial Arts.

B. Referenced dates applicable to Effective Dates, Termination Dates and Changes for Base Plan coverages will be:

■ The date the event occurs.

☐ The first day of the day of the month on or after the event occurs.

☐ Other: _____

C. Class **DESCRIPTION OF HAZARDS**

I. Sponsored and Supervised Activities for Boxing - 5 and under Bouts.

II. Sponsored and Supervised Activities for Boxing - 6-10 Bouts

III. Sponsored and Supervised Activities for Mixed Martial Arts.

D. Class **DESCRIPTION OF BENEFITS**

I, II, III Accidental Death, Dismemberment, or Loss of Sight.

I, II, III Accident Medical Excess.

I, II, III. Deductible

E. Class **PRINCIPAL SUM**

I, II, III $2,500-$5,000-$7,500-$10,000-$20,000-$25,000-$50,000-$100,000

I, II, III $2,500-$5,000-$7,500-$10,000-$20,000-$25,000-$50,000-$75,000-$100,000

I, II, III $250-$500-$1,000-$1,500-$2,000-$2,500-$3,000,$5,000

F. AGGREGATE LIMIT OF LIABILITY: $250,000 **per Accident** ■ Monthly ☐ Other_____

PER PERSON BY: Class: I,II,III **Rate:** _____

TOTAL NUMBER OF COVERED PERSONS: TBD **TOTAL PREMIUM: TBD**

4. **ADDITIONAL BENEFITS**

A. Class **DESCRIPTION** **Number Eligible**

B. Age Limits: Spouse: ☐ 70 ☐ Other:_____

Child: ☐ 19 (25 if student) ☐ Other:_____

C. Referenced dates applicable to Effective Dates, Termination Dates and Changes for Additional coverages will be:

☐ The date the event occurs.

☐ The first day of the day of the month on or after the event occurs.

☐ Other: _____

D. Class **DESCRIPTION OF HAZARDS**

E. Class **DESCRIPTION OF BENEFITS**

F. AGGREGATE LIMIT OF LIABILITY: $_____ **per** _____ ☐ Monthly ☐ Other_____

PER PERSON BY: Class: _____ **Rate:** _____

TOTAL NUMBER OF COVERED PERSONS: _____ **TOTAL PREMIUM: $**_____

5. AGE BASED REDUCTIONS: ☐ YES ☐ NO

6. PREMIUMS. Premiums are determined from the rates applicable to the specified Plan and Class. Premiums are due on _____ and the ____ day of each subsequent _____ and are paid by the Policyholder.

7. OPEN ENROLLMENTS: ☐ None. ☐ As Shown_____

8. TRANSMITTAL AGENT (appointed by Policyholder): ☐ None ■ As Shown: Arthur J Gallagher/Jason Dixon

SIGNED FOR THE POLICYHOLDER THIS _____**DAY OF** _____**,** _____**.**

Signature Name Title

***FOR COMPANY USE ONLY*:**

SALES OFFICE:_____

BROKER/AGENT:_____

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET BENEFITS
ACCIDENT ONLY POLICY

POLICYHOLDER: North American Boxing Federation

POLICY NUMBER: US095867

POLICY EFFECTIVE DATE: May 1, 2013

POLICY EXPIRATION DATE: April 30, 2014

This Policy is issued in the state of TEXAS and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

THIS IS ACCIDENT ONLY COVERAGE.

READ IT CAREFULLY.

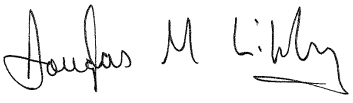
BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS POLICY IS NOT RENEWABLE.

Signed for **United States Fire Insurance Company** By:

Signature



Douglas M. Libby
Chairman and CEO

Signature

James Kraus
Secretary

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The following provisions appear within this Policy in the following order:

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	Provided treatment begins within 30 days from the date of Injury, Benefits are payable for 26 weeks from the date of an Injury. The Injury must occur after the Effective Date and prior to the Expiration Date and care must be Medically Necessary.
DEDUCTIBLE AMOUNT:	$250-$500-$1,000-$1,500-$2,000-$2,500-$3,000,$5,000
COINSURANCE PERCENTAGE:	100% of Usual, Reasonable & Customary (URC)
MAXIMUM BENEFIT AMOUNT:	**$**2,500-$5,000-$7,500-$10,000-$20,000-$25,000-$50,000-$75,000-$100,000

MEDICAL EXPENSE BENEFIT

Hospital Room & Board Daily Maximum Benefit Amount:	URC per day
Intensive Care Room & Board Daily Maximum Benefit:	URC per day
Hospital Miscellaneous Maximum Benefit Amount:	URC per day
Outpatient Pre-Admission Testing Benefit Amount:	URC
Outpatient Hospital Emergency Room Treatment Maximum Benefit Amount:	URC
Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	URC
Assistant Surgeon, Second Surgical Opinion, Consultation Maximum Benefit:	URC
Anesthesia Maximum Benefit:	URC
Surgical Facility Maximum Benefit per Operating Session:	URC
Doctor's Visits	
In-Hospital Maximum Benefit:	URC per visit
Office Visits Maximum Benefit:	URC per visit
Maximum for All In-Hospital and Office Doctor's Visits:	URC visits per Injury
X-ray and Laboratory Maximum Benefit Amount:	URC per procedure
Nursing Maximum Benefit Amount:	URC per Injury
Physiotherapy Benefit	
Maximum Benefit Amount (Hospital Inpatient):	URC
Maximum Benefit Amount (Outpatient):	URC
Maximum for All Physiotherapy Combined (Inpatient & Outpatient):	URC per Injury
Ambulance Maximum Benefit Amount:	URC
Medical Equipment Rental Charges Maximum Benefit Amount:	URC
Medical Services and Supplies Maximum Benefit Amount (Blood, Blood Transfusions, Oxygen):	URC
Dental Treatment For Injury Only	
Maximum Benefit Amount:	$200 per tooth

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

Maximum Benefit Amount:	URC per prescription

ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Principal Sum: $2,500-$5,000-$7,500-$10,000-$20,000-$25,000-$50,000-$100,000

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

"Accident" means a sudden, unforeseeable external event which:
(1) Causes Injury to one or more Covered Persons; and
(2) Occurs while coverage is in effect for the Covered Person.

"Benefit Period" means the period of time from the date of Injury, as shown in the Schedule of Benefits.

"Covered Person" means a person eligible for coverage as identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Policy.

"Deductible" means the amount of Eligible Expenses which must be paid by the Covered Person before benefits are payable under this Policy. It applies separately to each Covered Person.

"Dependent" means the Insured's unmarried child who:
(1) Has his principal residence with the Insured;
(2) Chiefly relies on the Insured for support and maintenance; and
(3) Is within the following age groups (unless otherwise shown in the Application):
    (a) Under 19 years of age;
    (b) 19 but less than 25 years of age and enrolled in a School as a full time student; or
    (C) 19 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

"Spouse" means the lawful Spouse, under age 70 (unless otherwise stated in the Application), of an Insured.

"Doctor" means a licensed practitioner of the healing arts acting within the scope of his license. Doctor does not include:
(1) The Covered Person;
(2) The Covered Person's spouse, child, parent, brother, or sister; or
(3) A person living with a Covered Person.

"Eligible Expenses" means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Policy is in force.

"He", "his" and "him" includes "she", "her" and "hers."

"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; or
(7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

"Hospital" means an institution which:
(1) Is operated pursuant to law;
(2) Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
(3) Is under the supervision of a staff of doctors;

(4) Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
(5) Has medical, diagnostic and treatment facilities, with major surgical facilities;
    (a) On its premises; or
    (b) Available to it on a prearranged basis; and
(6) Charges for its services.

“Hospital” does not include:
(1) A clinic or facility for:
    (a) Convalescent, custodial, educational or nursing care;
    (b) The aged, drug addicts or alcoholics; or
    (c) Rehabilitation; or
(2) A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    (a) The services are rendered on an emergency basis; and
    (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Injury" means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

"Medically Necessary" or "Medical Necessity" means the service or supply is:
(1) Prescribed by a Doctor for the treatment of the Injury; and
(2) Appropriate, according to conventional medical practice for the Injury in the locality in which the service or supply is given.

"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

"Usual, Reasonable and Customary means:
(1) With respect to fees or charges, fees for medical services or supplies which are;
    (a) Usually charged by the provider for the service or supply given; and
    (b) The average charged for the service or supply in the locality in which the service or supply is received; or
(2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which:
(1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
(2) Occurs while the person is a Covered Person under this Policy; and
(3) Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Full Excess Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount and Coinsurance Percentage (if any), 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 Covered Person must be under the care of a Doctor when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:
(1) While the person is insured under this Policy; or
(2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS: and
(1) Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
(2) Subject to compliance with the requirement, set forth in the Limitations section of this Policy.

PROVISIONS CONCERNING COVERED PERSONS

Eligibility:
Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the

Application who have completed any applicable Service Waiting Period. This includes anyone who may become eligible while this Policy is in force.

Effective Dates:
A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:
(1) The Effective Date of this Policy; or
(2) The day he becomes eligible according to the referenced date shown in the Application.

Termination:
Insurance for a Covered Person will end on the earliest of:
(1) The date he is no longer in an Eligible Class.
(2) The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    (a) The date the premium is fully earned; or
    (b) The Expiration Date of this Policy.
    This does not include Reserve or National Guard duty for training;
(3) The end of the period for which the last premium contribution is made; or
(4) The date this Policy is terminated.

DESCRIPTION OF HAZARDS

HAZARD: SPECIFIC ACTIVITY

We will pay the benefits described in this Policy, to the extent this Policy does not provide coverage, for a covered loss by a Covered Person engaged in Boxing, Wrestling, Kick Boxing & Mixed Arts.

Such activity must be:
(1) Under the auspices of the Policyholder;
(2) Authorized by the Policyholder; or
(3) Within the duties of his relationship to the Policyholder.

DESCRIPTION OF BENEFITS

BENEFIT A: BENEFITS FOR ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

If, within 1-year from the date of an Accident covered by this Policy, Injury from such Accident, results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, we will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

BENEFIT - MEDICAL EXPENSE

We will pay, Eligible Expenses for a Covered Person's Injury, subject to the Deductible Amount and Coinsurance Percentage, if any, shown in the Schedule of Benefits. Eligible Expenses are those incurred for:

(1) **Hospital Room and Board** – charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board.

(2) **Intensive Care Room and Board** - charges for each day of Intensive Care Unit confinement, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

(3) **Hospital Miscellaneous** - charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for the Hospital Miscellaneous benefit. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

(4) **Outpatient Hospital Expenses** - charges by a Hospital for:
   (a) Pre-admission testing (confinement must occur within 7 days of the testing); or
   (b) Emergency room treatment, up to the Maximum Benefit Amount per emergency shown in the Schedule of Benefits for the Outpatient Emergency Room Treatment benefit.

(5) **Surgical Benefits** - charges for:
   (a) A Doctor, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. However, we will pay up to 1.57 times the surgical procedure charge when more than one surgical procedure through different operating fields are performed during the same surgical session.
   (b) A Doctor, for: (i) assistant surgeon duties; (ii) a second surgical opinion; or (iii) consultation, up to the Maximum Benefit shown in the Schedule of Benefits for an Assistant Surgeon, Second Surgical Opinion, and Consultation.
   (c) Anesthesia and its administration, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Anesthesia benefit.
   (d) Use of surgical facilities, up to the Maximum Benefit Amount per operating session, as shown in the Schedule of Benefits for the Surgical Facility benefit.

(6) **Doctor's Visits** - charges by a Doctor for other than pre- or post-operative care:
   (a) For in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Doctor's Visit – In-Hospital.
   (b) For office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Doctor's Office Visits.

   Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Doctor's Visits.

(7) **X-Ray and Laboratory** - charges for X-ray and laboratory tests, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the X-ray & Laboratory benefit.

(8) **Nursing Services** - Charges for nursing services (other than routine Hospital care) by or under the supervision of a licensed graduate registered nurse, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Nursing benefit.

(9) **Physiotherapy -** Charges for physiotherapy:
   (a) While Hospital confined, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Hospital Inpatient Physiotherapy benefit;
   (b) As an outpatient, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

Physiotherapy includes:
(a) Heat treatment;
(b) Diathermy;
(c) Microtherm;
(d) Ultrasonic;
(e) Adjustment;
(f) Manipulation;
(g) Massage therapy and
(h) Acupuncture.

Total treatment per Injury will not exceed the Maximum Benefit Amounts for Physiotherapy shown in the Schedule of Benefits*.*

(10) **Ambulance** - from the place where the Injury occurred to the Hospital, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Ambulance benefit.

(11) **Medical Equipment Rental** - charges for medical equipment for:
(a) A wheelchair;
(b) An iron lung; or
(c) Other medical equipment for which prior approval by us has been given;
up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Equipment Rental benefit.

(12) **Medical Services and Supplies** - Charges for medical services and supplies for:
(a) Oxygen and its administration;
(b) Blood and blood transfusions;
up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Service & Supply benefit.

(13) **Dental Treatment** - Charges for dental treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Dental Treatment benefit.

The amounts payable under this Medical Expense benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Policy.

BENEFIT - OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Doctor on an outpatient basis.

Prescription Drug means a drug which:
(1) Under Federal law may only be dispensed by written prescription; and
(2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:
(1) On or after the Covered Person's Effective Date; and
(2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

The amount payable under this benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Certificate.

AGE BASED REDUCTIONS

At age 70 or more, benefits for a Covered Person will be based on the following percentages of his Principal Sum in effect without this provision.

Age On Date of Loss	Percentage of Principal Sum
70 through 74	65%
75 through 79	45%
80 through 84	30%
85 and over	15%

Premiums are based on the Principal Sum in force prior to applying the percentages in the above table.

EXCLUSIONS

Benefits will not be paid for a Covered Person's loss which:

(1) Is caused by or results from the Covered Person's own:
   (a) Intentionally self-inflicted Injury, suicide or any attempt thereat. (In Missouri this applies only while sane.);
   (b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);
   (c) Commission or attempt to commit a felony;
   (d) Participation in a riot or insurrection;
   (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
   (f) Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;
(2) Is caused by or results from:
   (a) Declared or undeclared war or act of war;
   (b) An Accident which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.);
   (c) Aviation, except as specifically provided in this Policy;
   (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted, unless a Sickness Expense Rider is enforce under this Policy. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.
   (e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
      (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
      (ii) The Covered Person was within a 25-mile radius of the site of the release either:
         1) At the time of the release; or
         2) Within 24 hours of the start of the release;

ADDITIONAL EXCLUSIONS

Benefits will not be paid for:

1. Normal health checkups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
   (a) Employed or retained by the Policyholder; or
   (b) Who is the Covered Person or a member of his immediate family;
4. Charges which:
   (a) The Covered Person would not have to pay if he did not have insurance; or
   (b) Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   (a) An aircraft, except as a fare-paying passenger;
   (b) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   (c) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
   (a) A snowmobile;
   (b) Any two or three wheeled motor vehicle;
   (c) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
   (a) The result of the Covered Person being Intoxicated. (“Intoxicated” will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
   (b) Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food, [unless a Sickness Expense Rider is in force under this Policy;
11. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
12. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
13. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
14. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
15. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
16. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
17. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
18. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
19. Any loss which is covered by state or federal worker's compensation, employer’s liability, occupational disease law, or similar laws;
20. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
21. Rest cures or custodial care;
22. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
23. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
24. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound;
25. Prescription medicines unless specifically provided for under this Policy.

LIMITATIONS

Any benefits payable under this Policy will be limited to the following:

(1) The medical benefits otherwise payable under this Policy will be reduced by 50% if:
   (a) Excess insurance is provided under this Policy; and
   (b) The Covered Person has coverage under another plan providing medical expense benefits; and
   (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and
   (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

   The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) In the event no consenting surgical opinion is obtained for those procedures that mandate such second surgical opinion, benefits payable for all Eligible Expenses associated with the procedure will be reduced by 50%. This limitation will apply whether the surgery is performed on an in-patient or out-patient basis. We will not cover a second opinion given more than 6 months after surgery was first recommended.

(3) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:
   a) Medically necessary for the care or treatment of a covered Injury;
   b) Received while coverage is in force under this Policy; and
   c) Rendered and/or prescribed by a licensed Doctor other than the Covered Person (or a member of his household or immediate family) in accordance with current medical standards and practices.

(4) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(5) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

AGGREGATE LIMIT

The Aggregate Limit of Liability is shown in the Application. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit of Liability, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit of Liability.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31-days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
(1) After the first 12 months insurance is in effect;
(2) Coinciding with a change in the coverage provided or classes eligible; or
(3) Coinciding with a change in the risks we have assumed.

We will give 31 days written notice of any change under (1) above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:
This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:
The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under this Policy.

We shall be permitted to examine the Policyholder’s records relating to coverage under this Policy. Examination may occur at any reasonable time up to the later of:
(1) The two year period after the expiration of the Policyholder's coverage; or
(2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:
The Policyholder or its authorized agent must report to us, by the premium due date:
(1) The names of all persons insured on the Effective Date of this Policy;
(2) The names of all persons who are insured after the Effective Date of this Policy;
(3) The names of those persons whose insurance has terminated; and
(1) Additional information required as agreed to by us and the Policyholder.

NEWLY ACQUIRED SUBSIDIARIES:
The premium for this Policy applies to the risks assumed on the Effective Date of this Policy. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under this Policy, subject to the following conditions:
(1) The Policyholder has at least 50% controlling interest in the subsidiary.
(2) An additional premium payment is required with a report to us and the name of any newly acquired subsidiary.
(3) Necessary underwriting information must be furnished for us to determine the additional risks assumed.
(4) Coverage will begin on the legal date of acquisition.

No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid Monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered

Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:
(1) The beneficiary named to receive a Covered Person's proceeds;
(2) Spouse;
(3) Child or children;
(4) Mother or father;
(5) Sisters or brothers; or
(6) The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)
The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:
(1) Received in a covered Accident; and
(2) Which are covered under:
    (a) workers' compensation or similar statutory remedies available under law; or
    b) Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

SUBROGATION:
If we have paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

DEPENDENT DEFINITION ENDORSEMENT

This Endorsement is attached to and made a part of the Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

The following Definition is hereby added or amended:

"Dependent" or **"Eligible Dependent"** means the Insured's Spouse under age 70; or Child who:

(a) Is under 26 years of age; and

(b) Is not provided coverage as a named subscriber, insured, enrollee, or coverage person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. section 1395 et seq.; or

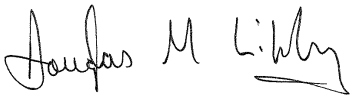
(c) A Child of any age who is medically certified by a Physician as having an intellectual disability or a physical disability and is dependent upon the Insured.

"Spouse" means the lawful Spouse, under age 70 (unless otherwise stated in the Application), of an Insured.

"Child" can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Signed for **The United States Fire Insurance Company** By:



Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way • Eatontown, NJ 07724

MANDATED BENEFITS COVERAGE RIDER

This Rider is attached to and made part of the policy as of the Effective Date. It is subject to all of the provisions, limitations and exclusions of the policy except as specifically modified by this Rider.

The following benefits are hereby added to the policy:

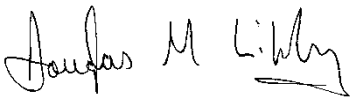
1. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services as a result of and related to an acquired brain injury.

2. Diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) which is medically necessary as a result of an accident or trauma.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED

This rider is part of the policy and takes effect with respect to each insured on the Effective Date of his term of coverage.

Signed for **United States Fire Insurance Company** By:



Douglas M. Libby
Chairman and CEO

TEXAS
IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the United States Fire Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-232-7380

You may also write to the United States Fire Insurance Company at:

The United States Fire Insurance Company
Complaint Department
c/o Fairmont Specialty
5 Christopher Way
Eatontown, NJ 07724

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

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

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, Texas 78714-9104

FAX No. 512-475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY. This Notice is for information only and does not become part of condition of the attached document.

TEXAS
AVISO IMPORTANTE

Para obtener informacion o para someter una queja**:**

Usted puede llamar al numero de telefono gratis de the United States Fire Insurance Company para informacion o para someter una queja al:

1-800-232-7380

Usted tambien puede escribir a United States Fire Insurance Company:

The United States Fire Insurance Company
Complaint Department
c/o Fairmont Specialty
5 Christopher Way
Eatontown, NJ 07724

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104
Austin, Texas 78714-9104

FAX No. 512-475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniete a su prima o a un reclamo, primero debe comunicarse con el agente. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento (TDI).

ANADA / ADJUNTE UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Texas Guaranty Notice

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life and Health Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.). However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify.

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY IN PART OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:
For each individual covered under one or more policies:

- up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance;
- $300,000 for disability or long term care insurance; and
- $200,000 for other types of health insurance, that are not defined as basic hospital, medical-surgical, major medical, disability, or long-term care insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
  - Present value of unallocated benefits up to a total of $5,000,000 for one contract owner regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

WHEN YOU ARE SELECTING AN INSURANCE COMPANY, YOU SHOULD NOT RELY ON COVERAGE BY THE ASSOCIATION.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or

www.tdi.state.tx.us

When used throughout this document "The Company", "Our", "We", or "Us" means:

☐ **United States Fire Insurance Company**

☐ **The North River Insurance Company**

☐ **Crum & Forster Indemnity Company**

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

When used throughout this document "Company", "Our", "We", or "Us" means:

☐ **United States Fire Insurance Company**

☐ **The North River Insurance Company**

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

GROUP ENROLLMENT FORM

This is an enrollment for Accident Only Coverage.

Please complete the information below for all persons to be covered.

Full Name	Sex	Relationship	Birth date	Social Security Number

Level of Coverage	**Monthly Premium**
Member Only _____ Member & One _____ Member & Family _____	$ **SEE PREMIUM REPORT**

FRAUD WARNING

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

_____ _____

Signature of Proposed Insured Date Signed: