



**ZURICH**<sup>®</sup>

ZURICH AMERICAN INSURANCE COMPANY

Schaumburg, Illinois

## Group Accident Policy

In return for the payment of premium expressed in the **Schedule**, **We** agree to pay the benefits of this Group **Accident Policy** to the persons insured hereunder, subject to the terms and conditions, which follow. **We** have issued the Group **Accident Policy** to the **Policyholder**. The Group **Accident Policy** is executed as of the **Policy** date which is its date of issue, and from which anniversary dates are measured. The Group **Accident Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

**THIS GROUP ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE ONLY  
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS**

**POLICYHOLDER:** University of Kentucky  
410 Administration Drive  
Lexington, KY 40506

**POLICY NUMBER:** GTU 5466939

**POLICY DATE:** July 1, 2015 to Continuous  
(All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

**CONTRACT SITUS:** Kentucky

The following pages, including any riders, endorsements, schedule pages, **Insured** enrollment forms, applications or amendments, are a part of this Group **Accident Policy**. **We** and the **Policyholder** have agreed to all the terms of this Group **Accident Policy**.

This is a legal contract between the **Policyholder** and **Us**.  
**READ THE GROUP ACCIDENT POLICY CAREFULLY**

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

Nancy D. Mueller  
President  
Zurich American Insurance Company

Dennis Kerrigan  
Corporate Secretary  
Zurich American Insurance Company

**NON-PARTICIPATING**

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## SECTION I – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

### ELIGIBILITY AND CLASSIFICATION OF INSURED(S):

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

**Class I:** All regular full-time employees of the **Policyholder**.

If an **Insured** suffers an **Injury** resulting in a **Covered Loss**, and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

### EFFECTIVE DATE OF INSURANCE FOR THE INSURED:

- A. For eligible individuals hired prior to July 1, 2015:  
July 1, 2015, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.
- B. For eligible individuals hired on or after July 1, 2015:  
On the first day of the month following the date the completed enrollment material is received by the **Policyholder**.

## SECTION II – SCHEDULE

### COVERAGES(S):

#### Classes Covered

24 Hour <b>Accident</b> Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft, Passenger Only, H-1	All
Exposure and Disappearance Coverage	All

### BENEFITS:

#### Classes Covered

#### ACCIDENTAL DEATH BENEFIT

All

##### Principal Sum:

**Class I:** One (1) times the employees **Base Annual Earnings\*** to a maximum of \$1,000,000.

\* **Base Annual Earnings** means the employee's base annual pay excluding overtime, bonuses, commissions and special compensation.

#### ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT

#### Classes Covered

All

##### Principal Sum:

Same as above.

Coma Benefit

All

### ADDITIONAL BENEFITS:

#### Classes Covered

Carjacking Benefit	All
Day Care Benefit	All
Hearing Aid or Prosthetic Appliance Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Rehabilitation Benefit	All
Spouse/Domestic Partner Retraining Benefit	All
Travel Assistance Plan	All

**ADDITIONAL ENDORSEMENTS****Form Number****Classes Covered**

Safety Device Benefit

U-VA-112-A KY (02/09)

All

Amendments to the **Policy**

U-VA-104-A CW (09/06)

All

Enrollment Required:

 Yes  No

Premium Due Date:

First day of each month

Premium: Employee Only:

\$0.016 per \$1,000 of **Principal Sum** per month

This rate is guaranteed until July 1, 2017.

**SECTION III – DEFINITIONS**

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

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

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

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

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

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

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

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

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

**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes the **Insured**.

**Dependent** means an **Insured's Spouse/Domestic Partner** and **Dependent Child(ren)**, as defined in this section.

**Dependent Child(ren)**, if used in this **Policy**, means those unmarried **Child(ren)** of the **Insured**, and those unmarried **Child(ren)** of his or her legally married **Spouse**, and those unmarried **Child(ren)** as defined in the **Policyholder's** medical plan as on file and approved by **Us** of the **Insured's Domestic Partner** who rely on the **Insured** for more than 50% of their support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 26 (twenty-six) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.

**Domestic Partner** means as defined in the **Policyholder's** medical plan as on file and approved by **Us**.

**Injury** means a bodily **Injury**.

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

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

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

**Policy** means this Group **Accident Insurance Policy**.

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

**Service Waiting Period** means the continuous length of time a person is required to be employed by the **Policyholder** prior to being covered under this **Policy**.

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

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

**Spouse**, if used in this **Policy**, means the **Insured's** legally married **Spouse**.

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

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

## SECTION IV – COVERAGES

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

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

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

#### **Hazard Limitations:**

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

- A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
  1. medical certificate; and
  2. pilot certificate with a proper rating to pilot such aircraft.
- B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

## Hazard Exclusions:

Coverage is not provided:

- A. If the **Insured** is the pilot, operator, member of the crew or cabin attendant of any aircraft.
- B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
  1. any aircraft other than those expressly stated in this **Coverage**;
  2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**;
  3. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of an **Insured's** family or household;
  4. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
  5. any aircraft engaged in a **Specialized Aviation Activity**;
  6. any conveyance used for tests or experimental purposes, or in a race or speed test.

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

## EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

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

## SECTION V – BENEFITS

### ACCIDENTAL DEATH BENEFIT

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

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

### ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT

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

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

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

## **Plegia**

- |   |                             |
|---|-----------------------------|
| 1. Quadriplegia (total paralysis of all four <b>Limbs</b> )                             | <b>Principal Sum</b>        |
| 2. Paraplegia (total paralysis of both lower <b>Limbs</b> )                             | 75% of <b>Principal Sum</b> |
| 3. Hemiplegia (total paralysis of upper and lower <b>Limbs</b> on one side of the body) | 50% of <b>Principal Sum</b> |
| 4. Uniplegia (total paralysis of one <b>Limb</b> )                                      | 25% of <b>Principal Sum</b> |

For purposes of this benefit:

1. **Covered Loss** means:
  - a. For a foot or hand, actual severance through or above an ankle or wrist joint;
  - b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - c. Total and permanent loss of sight;
  - d. Total and permanent loss of speech;
  - e. Total and permanent loss of hearing.
2. **Plegia** must continue for twelve (12) consecutive months and be determined by **Our** competent medical authority to be permanent, complete and irreversible paralysis of one or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

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

## **COMA BENEFIT**

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

The **Coma Benefit** is equal to 5% of the **Insured's Principal Sum**, and will be paid each month the **Insured** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. the **Insured** is no longer in a **Coma** which directly resulted from the **Injury**;
2. the **Insured** has received a **Coma Benefit** for 100 months.

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

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

## **SECTION VI – ADDITIONAL BENEFITS**

### **CARJACKING BENEFIT**

If an **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death or Accidental Dismemberment and Plegia Benefit**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the **Insured** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to 10% of the applicable **Principal Sum** to a maximum of \$50,000.

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

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

### **DAY CARE BENEFIT**

If an **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Dependent Child** if:

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

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

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

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

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

An **Accredited Child Care Facility** means:

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

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

### **HEARING AID OR PROSTHETIC APPLIANCE BENEFIT**

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

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

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

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified physician or surgeon who is not the **Insured's** spouse, child, or relative; and
2. presentation of proof of payment is provided to **Us**.

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

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

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Insured's Principal Sum** or \$25,000.

### **HIGHER EDUCATION BENEFIT**

If the **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**.

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

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

The **Higher Education Benefit** will be equal to 10% of the **Insured's Principal Sum**, to a maximum of \$50,000. This amount will be paid annually for four (4) consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering the **Insured's Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of \$2,000 to the designated beneficiary.

## HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

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

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

Benefits will not be payable unless:

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

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

## REHABILITATION BENEFIT

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

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. \$50,000; or
3. 10% of the **Insured's Principal Sum**.

**Rehabilitation Training** means a treatment program that:

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

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

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

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

## SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT

If an **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay to his or her **Spouse/Domestic Partner** the actual cost of any professional or trade-training program in which the **Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from the death of the **Insured**; and
3. the professional or trade training program is licensed by the state.

The maximum amount payable under this benefit will be the lesser of 3% of the **Insured's Principal Sum** or \$25,000.

## TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse/Domestic Partner** and or **Child(ren)** if the **Spouse/Domestic Partner** and or **Child(ren)** are with the **Insured** while he or she is covered under this **Policy**. The **Spouse/Domestic Partner** or **Child(ren)** will not be covered while making a trip without the **Insured**. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by Us. Under this **Policy**, the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

### **Medical Evacuation**

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

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

### **Medical Repatriation**

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

### **Non-Medical Repatriation**

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

### **Return of Remains**

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

### **Visit to Hospital**

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

### **Return of Child**

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

### **Return of Companion**

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

- **TRAVEL ASSISTANCE EXCLUSIONS**

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

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

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

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

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

“**Principal Residence**” means the legal domicile of the **Covered Person**.

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

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

**Right of Recovery**

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

**Reservation of Rights**

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

**Scope**

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

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

## SECTION VII – GENERAL EXCLUSIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony;
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity;
7. being intoxicated while operating a motor vehicle.
  - a. An **Insured** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
  - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured's** intoxication.
8. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
9. travel or flight in any aircraft except to the extent stated in the **Coverage** Section;
10. release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
11. a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;
12. alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider operating within his or her scope of authority.

## SECTION VIII – GENERAL LIMITATIONS

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

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

**Limitation on Multiple Hazards.** If an **Insured** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit unless there is a specific written exception in the **Policy**.

## SECTION IX - TERMINATION OF INSURANCE

### A. Policy Termination.

Termination by **Policyholder**. The **Policyholder** may terminate this **Policy** on the first renewal date or at any time after that date by delivering to **Us** a written notice to end this **Policy** at least thirty (30) days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

**Termination by Us.** **We** may terminate this **Policy** by giving the **Policyholder** at least thirty (30) days notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** may also end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the **Grace Period**. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

### B. Termination of Individual's Insurance.

**Insured.** Insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. the **Insured** ceases to be eligible for insurance;
3. the **Insured** fails to pay the required premium, if the **Insured** is so required;
4. the **Insured** reaches age 75;
5. the **Insured** retires.

## SECTION X - HOW TO FILE A CLAIM

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

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

**C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss**, and the proof was provided as soon as reasonably possible.

## SECTION XI - PAYMENT OF CLAIMS

- A. Time of Payment.** We will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.
- B. Who We Will Pay.**
1. Loss of Life of an **Insured**. **Covered Losses** resulting from the **Insured's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to the beneficiary named by the **Insured** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by the **Insured** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to the **Insured's** survivors in the following order:
    - a. the **Insured's** legally married **Spouse** or **Domestic Partner**;
    - b. the **Insured's** **Child(ren)**;
    - c. the **Insured's** parents;
    - d. the **Insured's** brothers and sisters;
    - e. the **Insured's** estate.
  2. All Other Claims. Benefits are to be paid to the **Insured**.
- C. Physical Examination and Autopsy.** We have the right to examine an **Insured** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- D. Choice of Service Provider.** The **Insured** has the sole right to choose his or her duly licensed physician and hospital.

## SECTION XII - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** The **Insured** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Insured** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.
- B. Change or Waiver.** A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.
- C. Clerical Error.** A clerical error or omission will not increase or continue an **Insured's Coverage**, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. Conformity with Statute.** Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.
- E. Entire Contract.** This **Policy**, the **Policyholder** application, **Insured** enrollment materials, and any attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. Grace Period.** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If the **Policyholder** does not pay a renewal premium when it is due, there is a thirty-one (31) day **Grace Period** to pay. During the **Grace Period**, the **Policy** will stay in force. The **Policyholder** will not have a **Grace Period** if **We** have given notice, at least thirty (30) days in advance, that **We** are going to terminate this **Policy**.
- G. Insured Certificates.** We will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Insureds**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**. Such **Certificate** will contain a summary of terms that affect benefits.

- H. Policyholder Records.** The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.
- I. Suit Against Us.** No action on this **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Insured** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- J. Renewal.** This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.
- K. ERISA Claims Fiduciary.** The **Policyholder** agrees that the **Policy** constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The **Policyholder** designates **Us** as the claims fiduciary of this plan and gives **Us** the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The **Policyholder** agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and **Our** designation and authority as the claims fiduciary.
- L. Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.
- M. Arbitration.** Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Insured**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured** is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the **Insured**.
- N. Newly Acquired Corporation** If the **Policyholder** acquires a corporation through stock purchase, exchange of stock or otherwise, and notifies **Us** of such acquisition within ninety (90) days thereafter, the eligible employees of the **Newly Acquired Corporation** will be insured under this **Policy** as of the effective date of such acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, within the ninety (90) days, or does not pay such additional premium, if any, as required, the **Coverage** for the employees of the **Newly Acquired Corporation** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

University of Kentucky  
GTU 5466939  
Effective: July 1, 2015

This endorsement, effective July 1, 2015, forms a part of **Policy** No. GTU 5466939, issued to University of Kentucky.

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This endorsement modifies insurance provided under the Group Accident Policy.

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

**SECTION II – SCHEDULE** is amended to include the following:

**ADDITIONAL BENEFITS:**

Safety Device Benefit

**Classes Covered**

All

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

**SAFETY DEVICE BENEFIT**

If an **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the **Accidental** death directly resulted from an **Accident**, **We** will pay an additional benefit, which equals 20% of the **Insured's Principal Sum** up to a maximum of \$50,000, provided that the **Insured** was:

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

Verification of the **Insured's** actual use of the Safety Device is required as follows:

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

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

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

#### **SAFETY DEVICE BENEFIT DEFINITIONS:**

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

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

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

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

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

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

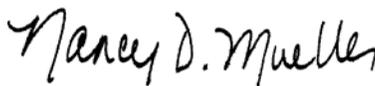
**Approved Protective Helmet** means a helmet complying with American National Standards Institute (ANSI) standard Z89.1-2003 or subsequent standard(s).

**Approved Body Armor** means a ballistic-resistant vest complying with National Institute of Justice (NIJ) Standard-0101.06 or subsequent standard(s).

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

Endorsement No. 1

Signed for by Zurich American Insurance Company



Date: July 16, 2015

AMENDATORY ENDORSEMENT  
**Administrative Change**



ZURICH AMERICAN INSURANCE COMPANY  
Schaumburg, Illinois

This endorsement, effective July 1, 2015, forms a part of **Policy** No. GTU 5466939, issued to University of Kentucky.

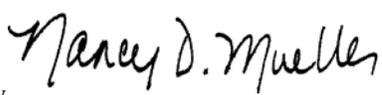
**AMENDMENTS TO THE POLICY**

It is hereby understood and agreed that effective July 1, 2015 the following changes will take place in the **Policy**:

- I. The definition of **Dependent Child(ren)** in the **Policyholder's** medical plan is incorporated into this **Policy** as if the language had been inserted into this **Policy** and replaces any definition of **Dependent Child(ren)** that currently exists in this **Policy**.
- II. The following exclusions are deleted in their entirety from **SECTION VII – GENERAL EXCLUSIONS** of the **Policy**:
  6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity;
  10. release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
  11. a cardiovascular event or stroke caused by exertion prior to or at the same time as an Accident;
  12. alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider operating within his or her scope of authority.

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

Endorsement No. 2

Signed for by Zurich American Insurance Company 

Date: July 16, 2015



**ZURICH**<sup>®</sup>

# **SANCTIONS EXCLUSION ENDORSEMENT**

**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

## **THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY**

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

### **SANCTIONS EXCLUSION**

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

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

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

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

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

### **ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED**



## Privacy Notice

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

Dear Customer:

rev October 2011

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

<b>Overview</b>	<b>UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION</b>
<b>Why are you receiving this Notice?</b>	Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company.
<b>What types of Information do we collect?</b>	<p>The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include:</p> <ul style="list-style-type: none"><li>• Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information;</li><li>• Information about your transactions with the Company and its affiliates;</li><li>• Information about your claims history;</li><li>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;</li><li>• Property information and similar data about you or your property; and</li><li>• Information we receive from a consumer reporting agency, such as a credit report.</li></ul> <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>
<b>What do we do with the nonpublic personal information we collect?</b>	WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING).

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

<b>Collecting and safeguarding information</b>	
<b>How often does the Company notify me about their practices?</b>	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision.
<b>Why and how does the Company collect my nonpublic personal information?</b>	<p>We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from:</p> <ul style="list-style-type: none"> <li>• Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income.</li> <li>• Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc.</li> <li>• Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance.</li> </ul> <p>Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.</p>
<b>What nonpublic personal information does the Company disclose?</b>	We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?".

<b>How does the Company safeguard my nonpublic personal information?</b>	Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.
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**FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, NORTH DAKOTA, OHIO OR VIRGINIA:**

**You have the following individual rights under state law:**

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1400 American Lane, T2 FL16, Schaumburg, IL 60196) or via email at [privacy.office@zurichna.com](mailto:privacy.office@zurichna.com). If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

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

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1400 American Lane, T2 FL16, Schaumburg, IL 60196) or via email at [privacy.office@zurichna.com](mailto:privacy.office@zurichna.com).

**FOR HEALTH INSURANCE POLICIES ISSUED IN NEVADA:**

If you wish to make a complaint or an inquiry concerning your health insurance policy, you may contact the Nevada Department of Business and Industry, Division of Insurance by calling (toll-free) (888) 872-3234. The hours of operation of the Division are Monday through Friday from 8 a.m. until 5 p.m., Pacific Standard Time.

<b>Key words and phrases</b>	<b>TERMS YOU SHOULD KNOW</b>
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<b>Definitions</b>	
<b>Everyday business purposes</b>	<p>The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as:</p> <ul style="list-style-type: none"> <li>• Processing transactions, mailing and auditing services</li> <li>• Administering insurance coverage, product, services or claims</li> <li>• Providing information to credit bureaus</li> <li>• Protecting against fraud</li> <li>• Responding to court/governmental orders or subpoenas and legal investigations</li> <li>• Responding to insurance regulatory authorities</li> </ul>

<b>Affiliates</b>	Financial or nonfinancial companies related by common ownership or control. <ul style="list-style-type: none"> <li>• <i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i></li> </ul>
<b>Non-affiliates</b>	Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services. <ul style="list-style-type: none"> <li>• <i>Company does not share information with non-affiliates to market to you.</i></li> </ul>
<b>Joint marketing</b>	A formal agreement between non-affiliated financial companies that together market financial products or services to you. <ul style="list-style-type: none"> <li>• <i>Company does not jointly market.</i></li> </ul>

<b>Changes to this Privacy Notice; contact us</b>	<p>We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.</p> <p>If you have any questions about your contract with us, you should contact your agent.</p> <p>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1400 American Lane, T2 FL16, Schaumburg, IL 60196) or via email at <a href="mailto:privacy.office@zurichna.com">privacy.office@zurichna.com</a>.</p>
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This Privacy Notice is sent on behalf of the following affiliated companies:

*American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Assurance Company of America, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Maryland Casualty Company, Northern Insurance Company of New York, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company").* This Privacy Notice applies to insurance products underwritten by or administered by the Company.