QBE INSURANCE CORPORATION

Administrative Office
55 Water Street
New York, NY 10041

RENEWAL AMENDMENT

This Amendment is attached to and made part of the Policy specified above. It is subject to all of the Policy provisions that do not conflict with its provisions.

Policyholder:	California State University – Risk Management Authority
Policy No.:	NHH000804
Amendment Effective Date:	December 31, 2019

Policyholder and We hereby agree that the Policy and any Certificates delivered under the Blanket Accident Policy are amended as follows:

1. An Additional Policy Term is added to Page 1. This Additional Policy Term is

   December 31, 2019 to December 31, 2020

   This Premium Guarantee is subject to the *Cancellation* and *Premium Rate Change* sections of the *Administrative Provisions* of this Policy.

QBE Insurance Corporation

Russell Johnston, President

QBE INSURANCE CORPORATION
Administrative Office
55 Water Street
New York, NY 10041

APPLICATION FOR BLANKET ACCIDENT INSURANCE
Accidental Death and Accident Medical Benefits

Part I Proposed Policyholder

a. Full Legal Name of Proposed Policyholder
California State University – Risk Management Authority – NHH000804

b. Address
401 Golden Shore, 5th Floor, Long Beach, CA 90802

c. Proposed Policyholder is **University**
please describe type of entity that will own policy

d. Requested Effective Date **July 1, 2019 to December 31, 2019**
Policy will become effective on the Requested Effective Date only if (a) all required information is provided and (b) all required premium is paid.

e. Who will be insured? Eligible Persons participating in Covered Activities as shown on the Schedule of Benefits

Part II Plan of Insurance and Premium Calculation

Plan of Benefits: Class 1 - Accident Medical Expense Benefits – Not Covered
Class 2 - Accident Medical Expense Benefits - $40,000

Scope of Coverage: Full Excess Deductible: Class 1 – Not applicable
Class 2 - $50,000

Accidental Death Benefit Class 1 - $15,000
Class 2 - $5,000
Accidental Dismemberment Benefit and Paralysis, up to Class 1 - $15,000
Class 2 - $5,000

Part III Acknowledgements and Signatures

a. Fraud Warning It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

b. Applicant's Acknowledgement I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of QBEIC will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of QBEIC, and (d) only those persons eligible under the terms of an issued policy will be insured.

Dated at _____ **on the** _____ **day of** _____ **, 20** _____

Signed for the Proposed Policyholder

Signed by Licensed Agent

Title

Agent License Number

QBE INSURANCE CORPORATION

Administrative Office
55 Water Street
New York, NY 10041

POLICYHOLDER:	California State University – Risk Management Authority
GROUP POLICY NUMBER:	NHH000804
POLICY EFFECTIVE DATE:	July 1, 2019
POLICY ISSUE DATE:	July 1, 2019
POLICY TERM	July 1, 2019 to December 31, 2019
STATE OF ISSUE:	California

QBE Insurance Corporation, herein called the Company or We, Us or Our, in consideration of the Application for this Policy and the timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the Policyholder's eligible member.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if premium is paid according to agreed terms.

This Policy terminates at 12:01 AM on the last day of the Policy Term unless the Policyholder and We have agreed to continue this Policy for an additional Policy Term. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

IN WITNESS WHEREOF QBE Insurance Corporation has caused this Policy to be executed on its Issue Date, to take effect on the Effective Date.

Russell Johnston, President

Jose Ramon Gonzalez, Secretary

• BLANKET ACCIDENT POLICY •
• NON-PARTICIPATING •

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY BENEFITS FOR SICKNESS

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

Eligible Persons: **Class 1** – All intercollegiate athletes, coaches, managers, trainers and band members of the schools.
Class 2 - All intercollegiate athletes, coaches, managers, trainers and band members of the schools.

Schools Covered:

CSU Bakersfield
CSU Chico
CSU Dominguez Hills
CSU East Bay
CSU Fresno
CSU Fullerton
Humboldt State
CSU Long Beach
CSU Los Angeles
California Maritime Academy
CSU Monterey Bay
CSU Northridge
California State Polytech University, Pomona
CSU Sacramento
CSU San Bernardino
San Diego State University
San Francisco State University
San Jose State University
Cal Poly State San Luis Obispo
CSU San Marcos
Sonoma State University
CSU Stanislaus

CONDITIONS OF COVERAGE
The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverage.

Class 1:

Sports Coverage

Personal Deviations covered	No
Covered Sports Travel Limits	Travel not Included

Covered Activities Participation in the Policyholder Supervised and Sponsored sports. Coverage does not include travel.

Class 2:

Sports Coverage

Personal Deviations covered	No
Travel arranged or provided by the Policyholder	No time limit

Covered Activities Group travel only for activities covered under Class 1. Covered travel means transportation arranged, provided, or paid for by the Policyholder. Overnight Supervised and Sponsored Activities with duration of more than 7 days and related travel are not covered unless specifically agreed to in writing by Us.

INDEMNITY BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – Class 1

Loss must occur within	365 days of the Covered Accident

Schedule of Covered Losses

Covered Loss	**Benefit**
Loss of Life	$15,000
Loss of Two or More Hands or Feet	$15,000
Loss of Sight of Both Eyes	$15,000
Loss of One Hand or Foot and Sight in One Eye	$15,000
Loss of Speech and Hearing	$15,000
Loss of One Hand or Foot	$ 7,500
Loss of Sight in One Eye	$ 7,500
Loss of Speech	$ 7,500
Loss of Hearing in Both Ears	$ 7,500
Loss of Thumb and Index Finger of the Same Hand	$ 3,750
Loss of all Four Fingers Of the Same Hand	$ 3,750
Loss of all Toes of the Same Foot	$ 3,750

Aggregate Limit of Indemnity	$500,000
Applies to:	All Conditions of Coverage

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses suffered by all Covered Persons insured under this Accidental Death and Dismemberment Benefit as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. If this amount does not allow all Covered Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – Class 2

Loss must occur within	365 days of the Covered Accident

Schedule of Covered Losses

Covered Loss	**Benefit**
Loss of Life	$5,000
Loss of Two or More Hands or Feet	$5,000
Loss of Sight of Both Eyes	$5,000
Loss of One Hand or Foot and Sight in One Eye	$5,000
Loss of Speech and Hearing	$5,000
Loss of One Hand or Foot	$ 2,500
Loss of Sight in One Eye	$ 2,500
Loss of Speech	$ 2,500
Loss of Hearing in Both Ears	$ 2,500
Loss of Thumb and Index Finger of the Same Hand	$ 1,250
Loss of all Four Fingers Of the Same Hand	$ 1,250
Loss of all Toes of the Same Foot	$ 1,250

Aggregate Limit of Indemnity	$500,000
Applies to:	All Conditions of Coverage

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses suffered by all Covered Persons insured under this Accidental Death and Dismemberment Benefit as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. If this amount does not allow all Covered Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENT MEDICAL EXPENSE BENEFITS

Any benefit limits and Benefit Percentages for Accident Medical Expense Benefits apply, unless otherwise specified, on a per-Covered Person – per Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

Scope of Coverage Applicable to Accident Medical Benefits

Full Excess Medical Expense	
Other Health Plan Reduction	0%

Medical Expense Benefits – Class 2 Only

Total Lifetime Maximum for all Accident Medical Expense Benefits	$40,000
First Covered Expenses must be Incurred within	90 days after a Covered Accident
Benefit Period	5 years from the date of the Covered Accident
Deductible	$50,000
applies to	each Covered Accident and includes Covered Expenses paid under another Health care Plan
Deductible must be satisfied within	365 days from the date of the Covered Accident

Covered Expense	**Benefit Amount, Percentage, Other Limits**
In-Patient Hospital Services	
Daily ICU or CCU Benefit	100%, up to two times the average semi-private room rate
Daily In-Hospital Benefit	100% of the average semi-private room rate
Miscellaneous Services	100%
Ambulatory Medical Center	100%
Emergency Room Treatment	100%
Physician Services	
Surgery Benefit	100%
Assistant Surgeon	100%
Physician's Surgical Facilities	100%

Second Opinion or Consultation	100%
Physician's Assistant	100%
Anesthesia Benefit	100%
Inpatient Visits	100%
Office Visits	100%
Outpatient X-Ray, CT Scan, MRI and Laboratory Tests	100%
Outpatient Physiotherapy	100%
Outpatient Nursing Services	100%
Ambulance Services	100%
Medical Equipment Rental	100%
Medical Services and Supplies	100%

Covered Services include:
(a) initial artificial limbs, eyes and larynx, including fitting; and
(b) replacement or repair of damaged eyeglasses, contact lenses or hearing aids.

Dental Services	100%
Prescription Drug Benefit	100%

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Aircraft means a vehicle which has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the Aircraft.

Appropriate Treatment means care, services or supplies, provided by or at the direction of a Physician that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury and are provided during the course of treatment of an injury sustained in a Covered Accident. Appropriate Treatment must be provided no less frequently than monthly, unless the Covered Person's Physician specifies in writing to Us that such treatment of injuries sustained in a Covered Accident can be provided at less frequent intervals.

Benefit Percentage means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the *Schedule of Benefits*.

Covered Activity means any recurring activity that is shown in the *Schedule of Benefits* and:

1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits;* and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

Company or **We, Us, Our,** means QBE Insurance Corporation (QBEIC), domiciled in Pennsylvania.

Covered Accident means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in an injury or loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, sickness, or mental or bodily infirmity; and
3. is not otherwise excluded under the terms of this Policy.

Covered Expenses means the lesser of the Usual and Customary Charge and the maximum benefit shown, for services or supplies listed, in the *Schedule of Benefits* and described in the *Accident Medical Expense Benefits* section of this Policy. Covered Expenses must be Incurred by a Covered Person for Appropriate Treatment for injuries sustained in a Covered Accident.

Covered Person means an Eligible Person, as defined in the *Schedule of Benefits*, whom for required premium has been paid when due and for whom coverage under this Policy remains in force.

Deductible means the amount of Covered Expenses that each Covered Person must Incur before benefits are paid under this Policy. The Covered Person may use Covered Expenses paid under another Health Care Plan to satisfy the Deductible under this Policy only if so indicated in the *Schedule of Benefits*.

He, Him or His means an individual, male or female.

Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;

4. coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice an individual practice plans;
5. medical benefits provided under automobile “fault” and no-fault” – type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid plan; or
   b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

Hospital means an institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2 it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3 it is managed under the supervision of a staff of medical doctors;
4 it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5 it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6 it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, or educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran’s Administration Hospital or Federal Government Hospitals unless the Covered Person Incurs an expense.

Hospital Stay means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident.

Incurred or Incurs means an obligation to pay for a Covered Expense for treatment, service or purchase of supplies, deemed to be the date it is provided to the Covered Person.

In-Patient means a Covered Person who is confined for at least one full day’s Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran’s Administration Hospital or Federal Government Hospital and in such case, the term “Inpatient” shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse means a licensed registered nurse (R. N.) or a licensed practical nurse (L. P. N.) who is not:
1. the Covered Person;
2. a parent, sibling, spouse or child of the Covered Person or the Covered Person’s spouse;
3. a person living in the Covered Person’s household; or
4. a person employed or retained by the Policyholder.

Out-Patient means a Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Personal Deviation means any activity which:
1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the *Conditions of Coverage* section of the *Schedule of Benefits.*

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the Policyholder; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Usual and Customary Charge means the normal charge, in the absence of insurance, made by the provider of any Appropriate Treatment, but not more than the prevailing charge in the area:

1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date
We agree to provide Blanket Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

Eligibility
An individual becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals
Insurance becomes effective for an Eligible Person on the latest of the following dates:
1. the effective date of this Policy; and
2. the date the individual becomes eligible.

Effective Date of Changes
Any increase or decrease in the amount of insurance for a Covered Person resulting from a change in benefits provided by this Policy will take effect on the date of such change.

Termination of Insurance
The insurance on a Covered Person will end on the earliest date below:
1. the date the person is no longer in an Eligible Class;
2. the end of the last period for which premium is paid; or
3. the date this Policy terminates.

Termination will not affect a claim for a Covered Loss resulting from a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:
1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit or Maximum, as shown in the *Schedule of Benefits,* have been paid;
3. the date benefits paid equal any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits.*

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. travel or activity outside the United States or Canada;
12. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. injuries compensable under Workers' Compensation law or any similar law;

We will not pay benefits for:

15. services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Policyholder;
    b. living in the Covered Person's household;
    c. who is a parent, sibling, spouse or child of the Covered Person;
16. any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.
17. A Covered Person's Covered Loss if:
    a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and
    b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after the occurrence or commencement of a Covered Loss, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person to Us at Our Administrative Office in New York, New York, or to any authorized agent of Ours with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Claim Forms
We, upon receipt of a written or authorized electronic/telephonic notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written or authorized electronic proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Proof of Loss
Written or authorized electronic proof of loss must be furnished to Us, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment of Claims
We will pay benefits due under this Policy immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

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. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Beneficiary
The beneficiary is the person or persons the Covered Person names or changes on a form executed by him. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes or to make any assignment of rights or benefits permitted by this Policy, unless the beneficiary has been designated as an irrevocable beneficiary.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the estate of the Covered Person.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the person of the Covered Person whose Covered Accident is the basis of claim when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

Under California regulation, it is Our obligation to provide the Covered Person a written accounting of the basis for overpayment.

ADMINISTRATIVE PROVISIONS

Cancellation
We or the Policyholder may cancel this Policy as of any Premium Due Date by giving the other 60 days advance written notice. Any premium rate guarantee will not affect Our or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, We will cancel this Policy at the end of the last period for which premium was paid, subject to any Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits.*

Cancellation will not affect a claim for a Covered Loss resulting from a Covered Accident that occurred before the cancellation date.

Premiums
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits.* We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Payment
The total premium paid by the Policyholder is the sum of premiums for all Covered Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits,* unless the Policyholder and We agree to another mode of premium payment. Premiums are paid at our Administrative Office or to Our authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates
We may change the premium rates from time to time with at least 31 days advance written notice to the Policyholder. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects Our benefit obligations under this Policy; or
3. the Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit
We will have the right to audit books and records of the Policyholder at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to the earliest period for which premium was not previously paid.

GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the endorsements, amendments and any attached papers, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Misstatement of Fact
If a Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Assignment
The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.

Incontestability
1. Of This Policy

All statements made by the Policyholder to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used 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 the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

Reporting Requirements
The Policyholder or its authorized agent must report all of the following to Us by the premium due date:
1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by Us.

Clerical Error
A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes
Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

CONDITIONS OF COVERAGE

This section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

SPORTS COVERAGE

Provisions, exclusions and other conditions concerning travel apply only if indicated on the Schedule of Benefits.

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Loss or Incurs Covered Expenses resulting directly and independently of all other causes from a Covered Accident that occurs while he is participating in one of the following Sports Covered Activities:

1. regularly-scheduled practice or training;
2. regularly-scheduled competition or exhibition game;
3. a scheduled tryout, workout session or team meeting;
4. a Supervised and Sponsored Sports Activity; or
5. Covered Sports Travel.

Covered Sports Travel includes travel only within the United States and only directly and without interruption:

1. between home and the premises of the Sports Organization;
2. between home and another meeting place designated by the Sports Organization;
3. between home and another site designated by the Sports Organization, where a Supervised and Sponsored Sports Activity is scheduled;
4. between the premises of the Sports Organization or other meeting place it designates and another site where a Supervised and Sponsored Sports Activity is scheduled.

Travel Coverage for Overnight Supervised and Sponsored Sports Activities
Covered Sports Travel also includes travel to a Supervised and Sponsored Sports Activity, within or outside the United States when a Covered Person's participation in or attendance at it requires him to be away from his normal residence for a stay of one or more nights. Coverage for travel to any Covered Activity that takes place outside the United States will be covered only if We have agreed to it in writing.

Definitions

For purposes of this coverage:

Sports Organization means a School, college or university, team, league or other organization, as named in the *Schedule of Benefits*, that organizes, sponsors, supervises, schedules or otherwise provides Sports Covered Activities.

Supervised and Sponsored Sports Activity means a Covered Activity that:

1. takes place:
   a. on a Sports Organization's premises during scheduled hours;
   b. at another site at which the Covered Activity is scheduled; and
1. is sponsored, organized or otherwise provided by the Sports Organization; and
2. is supervised by a coach, referee, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the Sports Organization.

Supervised and Sponsored Sports Activity does not include participating in any activity, including tryouts, practice or any competitions or games for any sports activity not specifically shown in the *Schedule of Benefits.*

Covered Sports Travel means transportation for a Covered Person on a common carrier, Policyholder-provided bus or van, or private passenger automobile driven by an adult with a valid driver's license. It will also include travel by foot or non-motorized bicycle between the Covered Person's home and a Supervised and Sponsored Sports Activity.

Exclusions

1. This coverage will not be in effect during any sports activity unless it is sponsored, organized, supervised scheduled or otherwise provided by the Sports Organization named in the *Schedule of Benefits*.
2. This coverage will not be in effect during travel to any Covered Activity that takes place outside the United States unless We have agreed in advance to provide it.
3. This coverage will not be in effect during a Covered Person's Personal Deviation.

Other exclusions that apply to this coverage are in the *Common Exclusions* Section.

WITH TRAVEL

ACCIDENT INDEMNITY BENEFITS

This Section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts and any applicable time requirements and limitations are shown in the *Schedule of Benefits.* Please read this and the *Common Exclusions* section in order to understand all of the terms, conditions and limitations applicable to these benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss
We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, the total of Benefits We will pay will not exceed the Principal Sum.

If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the Principal Sum.

Definitions *Each definition described below will apply to this Policy only if a corresponding Covered Loss is listed for it in the Schedule of Benefits.*

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 all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance of at least one whole phalanx of the same hand.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

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

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

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

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

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

SCOPE OF COVERAGE APPLICABLE TO MEDICAL EXPENSE BENEFITS

Only the Scope of Coverage listed on the Schedule of Benefits will apply.

Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits.*

Other Health Care Plan Benefits
When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

Primary Medical Expense
We will pay Covered Expenses without regard to any Health Care Plan the Covered Person may have, after any applicable Deductible has been satisfied.

Primary Excess Medical Expense
We will pay Covered Expenses, up to the Primary Excess Benefit shown in the *Schedule of Benefits* after the Covered Person satisfies any applicable Deductible, without regard to any other Health Care Plan he may have. We then pay Covered Expenses only when they are in excess of amounts payable by any other Health Care Plan, whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits* if:
1. the Covered Person has coverage under another Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses will not be reduced for:
(a) emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement; and
(b) services rendered in a non-network facility or by a non-network provider, when such services are required for emergency treatment within 24 hours of a Covered Accident.

Full Excess Medical Expense
We will pay Covered Expenses:
1. after the Covered Person has satisfied any applicable Deductible; and
2. only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits* if:
1. the Covered Person has coverage under another Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses will not be reduced for:

(a) emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement; and
(b) services rendered in a non-network facility or by a non-network provider, when such services are required for emergency treatment within 24 hours of a Covered Accident.

Definitions For purposes of the Accident Medical Benefits provided by this Policy:

HMO or Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider or service.

PPO or Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform those services at rates lower than non-Preferred Providers.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits shown in the *Schedule of Benefits* for Covered Expenses Incurred by a Covered Person, subject to all applicable conditions and exclusions, for treatment of an injury that resulted directly and independently of all other causes from a Covered Accident.

Benefits will be paid:

1. when Covered Expenses Incurred exceed any applicable Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits*; and
2. as long as the first expense has been Incurred within the number of days specified in the *Schedule of Benefits;* and
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired; and
4. until the total of Covered Expenses paid equals any applicable Benefit Limit or maximum benefit shown in the *Schedule of Benefits;* and
5. until benefits paid equal the Maximum for Accident Medical Expense Benefits shown in the *Schedule of Benefits*.

Covered Expenses

Inpatient Hospital Services

Room and Board Expenses – We will pay for

1. confinement in an intensive or coronary care unit, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of such confinement; and
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses – We will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for outpatient surgery. Miscellaneous Expenses include, but are not limited to, X-ray, laboratory, in-Hospital physiotherapy, nurse services, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay.

Ambulatory Medical Center

We will pay Covered Expenses Incurred for medical or surgical treatment provided in a licensed facility that provides ambulatory surgical or medical treatment and is not a Hospital or Physician's office.

Emergency Room Treatment

We will pay Covered Expenses Incurred for outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits.* When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense.

Physician Services – We will pay Covered Expenses for Covered Expenses listed below.

Surgery

1. Covered Expenses charged for performing a surgical procedure through one incision. For the second procedure through the same incision, during the same surgical session, we will pay up to an additional 50% of the benefit payable for the primary surgical procedure. For the third procedure and each procedure thereafter through the same incision, during the same surgical session, we will pay up to an additional 25% of the benefit payable for the primary surgical procedure; and
2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure;

3. Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital or an ambulatory surgical center;
4. Any braces, splints or other devices required after surgery to ensure proper healing.

Use of Physician's Surgical Facilities – Covered Expenses charged for the use of a Physician's surgical facilities.

Second Opinion or Consultation – Covered Expenses charged by a Physician for a second surgical opinion or consultation.

Physician's Assistant – Covered Expenses charged by a Physician's Assistant for other than pre-or post-operative care, second opinion or consultation:
1. for in-Hospital visits; and
2. for office visits.

Anesthesia and its administration – Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre-or post-operative care, second opinion or consultation;
1. for in-Hospital visits; and
2. for office visits.

Outpatient X-Ray, CT Scan, MRI and Laboratory Tests

We will pay Covered Expenses Incurred for X-rays except dental X-rays, CT Scans, MRI's and laboratory tests.

Outpatient Physiotherapy

We will pay Covered Expenses Incurred for outpatient physiotherapy, which includes (a) acupuncture, (b) microthermy, (c) chiropractic adjustment, (d) manipulation, (e) diathermy, (f) massage therapy, (g) heat treatment, and (h) ultrasound treatment.

Outpatient Nursing Services

We will pay Covered Expenses Incurred for services other than routine Hospital care, rendered by a Nurse.

Ambulance Services

We will pay Covered Expenses Incurred for ground or air ambulance service to transport a Covered Person from the place where a Covered Accident occurred to the nearest medically appropriate facility. We will pay Covered Expenses Incurred for ground ambulance transportation from the nearest medical facility to another appropriate medical facility if a Physician specifies in writing that specialized care not available in the first facility to which the Covered Person was transported is necessary to treat his injury.

Medical Equipment Rental

We will pay Covered Expenses Incurred for rental or, if less, for purchase of:
1. a wheelchair or hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Covered Person and that can only be used by him. Examples of items that are not covered include but are not limited to computers, motor vehicles and modifications thereof, and ramps and installation costs.

Medical Services and Supplies

We will pay Covered Expenses Incurred for:

1. blood and blood transfusions, including processing and administration; and
2. cost and administration of oxygen and other gasses.

We will not pay for storage of blood for any reason.

Dental Services

We will pay Covered Expense Incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include examinations, X-rays, restorative treatment, endodontics, oral surgery, initial braces required for treatment of an injury and treatment of gingivitis resulting from trauma.

Covered Expenses must be Incurred within the Benefit Period shown in the *Schedule of Benefits.* If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

We will pay Covered Expenses Incurred for drugs that

1. can only be obtained through a Physician's written prescription; and
2. are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay Covered Expenses Incurred for drugs that meet (a) above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA. The Covered Expense for a prescription drug is limited to the cost of a generic drug unless substitution of a generic drug is prohibited by law, no generic drug is available, or the Covered Person's Physician specifically request that a non-generic drug be dispensed.

Excluded Expenses

None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
   - a cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
   - b reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations.
4. Examination or prescriptions for, or purchase of, eyeglasses, contact lenses or hearing aids.
5. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.

8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. Personal services such as television and telephone, or transportation.
10. Expenses payable by any automobile insurance policy without regard to fault.
11. Services or treatment provided by an infirmary operated by the Policyholder.
12. Treatment of injuries that result over a period of time, such as blisters, tennis elbow, et al, that are a normal, foreseeable result of participation in the Covered Activity.
13. Treatment or service provided by a private duty nurse.
14. Treatment of hernia of any kind.
15. Treatment of injury resulting from a condition that a Covered Person knew existed on the date of a Covered Accident, unless we have received a written medical release from his Physician.

Other Exclusions that apply to this Benefit are in the *Common Exclusions* Section.

LIMITATIONS

When the Scope of Coverage indicated in the Schedule of Benefits is Primary Medical Expense, this provision applies.

Non-Duplication of Benefits

This provision applies if:

1. any other Health Care Plan covers the Covered Person; and
2. total benefits under all Plans would exceed the expenses actually incurred; and
3. We are not defined as primary under another Health Care Plan's Coordination of Benefits provision.

When the total of benefits payable by all Health Care Plans, whether or not claim is made for those benefits, exceeds Covered Expenses incurred, any Expense-Incurred Medical Benefits We pay will be reduced by such excess.

When the Scope of Coverage indicated in the Schedule of Benefits is Primary Excess Medical Expense or Full Excess Medical Expense, this provision applies.

Non-Duplication of Benefits When This Policy and Other Plans Are Excess

This provision applies if benefits under any other Health Care Plan are Covered Expenses under this Policy and coverage under this Policy and the other Plan are excess.

We pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses.

Our pro rata share equals the total of benefits payable under this Policy multiplied by a fraction, of which the numerator is the benefits We pay and the denominator is the total of benefits payable by all Health Care Plans for the same Covered Accident.

FACTS

WHAT DOES QBE DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some, but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and payment history • Medical information and purchase history • Credit-based insurance scores and insurance claim history When you are **no longer** our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons QBE chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does QBE share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	Call 800-362-5448 or go to www.qbe.com/us

Who we are

Who is providing this notice?	General Casualty Company of Wisconsin, General Casualty Insurance Company, Hoosier Insurance Company, North Pointe Insurance Company, Praetorian Insurance Company, QBE Americas, Inc., QBE Insurance Corporation, QBE Specialty Insurance Company, Regent Insurance Company, Southern Fire & Casualty Company, Southern Pilot Insurance Company, Stonington Insurance Company, Unigard Indemnity Company, Unigard Insurance Company

What we do

How does QBE protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information about you to staff on a "need to know" basis.
How does QBE collect my personal information?	We collect your personal information, for example, when you: • Apply for insurance or pay insurance premiums • File an insurance claim or provide employment information • Give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • sharing for affiliates' everyday business purposes—information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include the financial companies listed in the "Who is providing this notice?" section.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • QBE does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • QBE does not joint market.

Other important information

We may give your personal information to insurance support organizations that may keep it or give it to other companies that may use the same service. We may share medical information so we can learn if you qualify for coverage, process claims or prevent fraud, or if you say we can. To see your information, write to us at **QBE, Attn: Privacy Official, Corporate Legal Department, One General Drive, Sun Prairie, WI 53596** and provide us with your name, address, date of birth and policy numbers. Within 30 days of receipt, we will tell you what information we have. You may write us and ask us to correct, amend or delete any information that is incorrect. We will let you know what action we take. If you do not agree with our actions, you may send us a rebuttal statement.

AZ, CA, GA, IL, ME, MA, MN, MT, NV, NJ, NM, NC, ND, OH, OR, VT and VA customers. We may not disclose your personal information with non-affiliated third parties unless you authorize us to, or if permitted by law.

California customers. We limit sharing information about you among our affiliates unless allowed by California law.

Maine customers. You have the right to know the reasons for an adverse underwriting decision. Previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless we make an independent evaluation of the underlying facts. You have the right not to be subjected to pretext interviews.

North Carolina customers. We may not disclose your Social Security number unless you authorize us to, or if permitted by law.

NOTICE TO POLICYHOLDERS/INSUREDS

We are here to serve you...

As our policyholder/insured, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied...

If you have any questions or complaints about your insurance, please write to our Director of Claims or Department of Consumer Relations at the following address, or call us using our toll-free telephone number.

QBE Insurance Corporation
55 Water Street
New York, New York 10041
877-772-6771

If, after contacting us, you feel that your problem is not resolved or you are not being treated fairly, you may contact the California Department of Insurance by writing to them at the following address or using their toll-free telephone number:

Consumer Services Division
State of California
Department of Insurance
300 South Spring Street
South Tower, Suite 201
Los Angeles, CA 90013

Toll-Free Consumer Hotline in California: 1-800-927-HELP
Area codes 213, 310, and 818 and out-of-state: 1-213-897-8921

QBE.

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.