



Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [399 Park Avenue, 8th Floor, New York, NY 10022]

Occupational Accident Policy

POLICYHOLDER: [ABC Employer]
POLICY NUMBER: [12345678]
POLICY EFFECTIVE DATE: [07-01-09 at 12:01 A.M.]
POLICY TERM: [07-01-09 at 12:01 A.M. to 07-01-10 at 12:01 A.M.]
STATE OF DELIVERY: Texas

The Policy takes effect on the Policy Effective Date shown above at 12:01 A.M. Standard Time at the address of the Policyholder where this Policy is delivered. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:01 A.M. Standard Time at the address of the Policyholder at end of the Policy Term unless the Policyholder and We agree in writing to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium due date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

Signed for STARR INDEMNITY & LIABILITY COMPANY:

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE POLICY, AND IF THE EMPLOYER IS A NONSUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NONSUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THE POLICY CONTAINS A MANDATORY ARBITRATION PROVISION AND IS GOVERNED BY THE FEDERAL ARBITRATION ACT.

PLEASE READ THE POLICY CAREFULLY.

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may contact [GreenWood International Insurance Services] at

[1-800-272-7488]

- You may call Starr Indemnity & Liability Company's toll free number for information or to make a complaint at

[1-800-XXX-XXXX]

- You may also write to Starr Indemnity & Liability Company at

[90 Park Avenue
New York, NY 10016]

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

1-800-252-3439

- You may write the Texas Department of Insurance at

P.O. Box 149104
Austin, Texas, 78714-9104
FAX # (512) 475-1771

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

E-mail: ConsumerProtction@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES

Should You have a dispute concerning Your premium or about a claim You should contact the [agent] or Starr Indemnity & Liability Company first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

- Puede comunicarse con su [GreenWood International Insurance Services] al

[1-800-272-7488]

- Usted puede llamar al numero de telefono gratis de Starr Indemnity & Liability Company's para informacion o para someter una queja al

[1-800-XXX-XXXX]

- Usted tambien puede escribir a Starr Indemnity & Liability Company al

[90 Park Avenue
New York, NY 10016]

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

1-800-252-3349

- Puede escribir al Departamento de Seguros de Texas at

P.O. Box 149104
Austin, Texas, 78714-9104
FAX # (512) 475-1771

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

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) o Starr Indemnity & Liability Company primero. Si no se resuelve la disputa, puede enonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA

Este aviso es solo para preposit de informacion y no se convierte on parte o condicion del documento adjunto.

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SCHEDULE OF BENEFITS

POLICYHOLDER: [ABC Employer]
COVERED BUSINESS LOCATION(s): [123 Main Street, Anytown, USA 12345]

BENEFIT LIMITS

A) Accidental Death and Dismemberment or Loss of Use – Principal Sum: [10 X Base Earnings not to exceed [\$100,000 to \$500,000]]

B) Accident Medical Expense Benefit
Maximum Accident Medical Expense Benefit [\$50,000 - \$5,000,000]
Accident Medical Expense Benefit Period: [52-156 weeks]

Coinsurance Rate:

Preferred Provider [100%] of UCR Charges
Non-preferred Provider [80% - 100% of UCR Charges]

C) Disability Benefit

Weekly Benefit: The lesser of [70% – 100%] of the Insured's Average Weekly Earnings or [\$600], minus Other Income Benefits.

Waiting Period: [0 – 30] days of continuous Disability for each Insured per Occurrence

Disability Benefit Period: [52-156] weeks

COVERAGE LIMITS AND DEDUCTIBLE

The below Limits of Liability and Deductible are applicable to all benefits under the Policy:

- a.) [Maximum Benefit Amount Per Insured [\$100,000 - \$5,000,000]]
[Combined Single Limit (per Insured [per Occurrence]): [\$100,000 – \$5,000,000]]
- b.) Aggregate per Occurrence: [\$10,000,000]
- c.) Deductible ([per Insured] per Occurrence): [\$0 - \$500,000]
- d.) Policy Aggregate Limit: [\$25,000,000]

We will not pay more than the Policy Aggregate Limit for all Covered Losses during the Policy Term. Principal Sum is defined as 10x Base Earnings to a maximum of the Combined Single Limit or Accidental Death and Dismemberment or Loss of Use – Principal Sum, whichever is the lesser amount.

PREMIUM – Premium adjusted at a rate per Eligible Person

Class	Description of Classes of Eligible Persons	Rate per [Eligible Person][Monthly Payroll]
[XYZ123]	[All eligible workers of ABC Employer]	[Class_Rate]
A) Deposit Premium:	[\$\$\$]	
B) Premium Percentage of Payroll:	[XX%]	
C) Total:	[\$\$\$]	
D) Premium Due Date:	[10th of each month]	
E) Payment Mode:	[Monthly, Quarterly, Annually]	

THE POLICY INCLUDES THE FOLLOWING FORMS AND ENDORSEMENTS AT ISSUE:

Group Master Application
[ABC Rider

AH-10002
AH-XXXXXX]

**THE POLICY CONTAINS A MANDATORY ARBITRATION PROVISION AND IS GOVERNED BY THE
FEDERAL ARBITRATION ACT.**

DEFINITIONS

Please note, certain words used in this document have specific meanings. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

"Accident" means an external sudden, unexpected and unintended event that occurred during the Policy Term at a specifically identifiable time and place and arose within the Eligible Person's Scope of Employment.

"Active Service" means an Insured is either 1) actively at work performing all regular duties on a full-time basis either at the Policyholder's place of business or someplace the Policyholder requires him or her to be in the course of his or her Scope of Employment; or 2) actively at work performing restricted or modified duty work at the direction of the Policyholder in the course of his or her Scope of Employment; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

"Administrator" means administrator as designated in the Group Master Application.

"Appropriate Care" means the determination of an accurate and medically supported diagnosis and on going medical treatment and care of the Eligible Person's condition or Disability by a Physician that conforms to generally-accepted medical standards, including frequency of treatment and care.

"Average Weekly Earnings" means an Eligible Person's Base Earnings divided by fifty two (52).

"Base Earnings" means an Eligible Person's annual wage or salary as reported by the Policyholder for work performed for the Policyholder as in effect just prior to the date of the Covered Loss. It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

For commissioned Eligible Persons, Base Earnings shall be the average annual earnings as reported by the Policyholder for work performed over the then most recent three (3) year period. If the Eligible Person was not employed by the Policyholder for a full consecutive three (3) year period, Base Earnings means the Eligible Person's average monthly earnings from the Policyholder for the months employed multiplied by twelve. For commissioned Eligible Persons, Base Earnings do include commissions, but do not include bonus, overtime pay or other extra compensation.

For hourly Eligible Persons, Base Earnings means an Eligible Person's earnings as reported by the Policyholder for work performed for the 12 months immediately prior to the date of the Covered Loss. If the Eligible Person was not employed by the Policyholder for a full consecutive 12 month period, Base Earnings means the Eligible Person's average monthly earnings from the Policyholder for the months employed multiplied by twelve. It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

"Chiropractic Care" means chiropractic treatment or therapy provided by a person appropriately licensed to provide chiropractic services, who is not also a member of the Eligible Person's Immediate Family or household.["Combined Single Limit Per Insured" is the highest dollar amount We will pay to any one of the Insureds whether payments are made under one or more of the benefits provided by this Policy for any one claim for Covered Losses.]

["Combined Single Limit Per Occurrence" is the highest dollar amount We will pay to or on behalf of all Insureds who suffer injuries as a result of any one claim for Covered Losses.]

"Covered Accident" means an Accident that occurs during the Policy Term while coverage is in force for an Insured and that results in a Covered Loss.

"Covered Class" means the Classes of Eligible Persons under the Policy. Covered Classes are shown in the Schedule of Benefits.

"Covered Loss" or "Covered Losses" means an accidental death, dismemberment, loss of use or Injury covered under the Policy for which benefits are payable.

"Cumulative Trauma" means damage to the physical structure of the body occurring as the sole result of repetitious, physically traumatic activities that occur solely within the Eligible Person's Scope of Employment. Cumulative Trauma excludes Occupational Injury.

"Deductible" means the dollar amount shown in the Schedule of Benefits that the Policyholder must pay before We will pay any benefits under the Policy. We will not pay for sums that do not exceed the Deductible amount.

["Defense Costs" is the amount equal to 15% of the Combined Single Limit. Once this Limit is exhausted any amount reimbursed in excess of the Limit on Defense Costs will accumulate to the Combined Single Limit and will be less any reimbursements made for the Insured under the Policy for the same Occurrence.]

"Disability Benefit Period" is the maximum period that Disability Benefits may be paid by Us for any one Occupational Injury. It is shown on the Schedule of Benefits.

"Disease" means a condition marked by a pronounced deviation from the normal healthy state of an Eligible Person that is first diagnosed or treated by a Physician while the Policy is in force with regard to the person whose sickness is the basis of claim.

"Eligible Medical Expense" means expenses actually incurred by or on behalf of an Insured for treatment, services and supplies covered by the Policy. An Eligible Medical Expense is deemed to be Incurred.

"Eligible Person" means a person who is in one of the Covered Classes and, at the time of an Occurrence, is employed in the regular business of, is under the direction and control of, and receives compensation on a regular basis by means of a salary or wage directly from the Policyholder. Eligible Person includes only those persons who, at the Policyholder's direction, work in Texas, or temporarily outside of Texas, in the Policyholder's regular business.

"Hospital" means an institution that: 1) operates as a hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Nurses on duty or call; 3) has a staff of one or more licensed Physicians available at all times; 4) provide organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a hospital used as such; 6) is not a place for the care and treatment of mentally ill, emotionally ill or retarded persons; and 7) is not a place for drug addicts, alcoholics, or the aged.

"Incurred" means the date a treatment, service or supply, that gives rise to the expense or the charge, was rendered or obtained.

"Immediate Family" means an Insured's parent, grandparent, spouse, child, brother, sister or in-laws.

"Injury" means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All Injuries sustained by one person in any one Accident, including all related conditions and recurring symptoms of these Injuries, are considered a single Injury.

"Insured" means an Eligible Person in a Covered Class under the Policy and for whom the required premium is paid making insurance in effect for that person. Insured is also referred to as "You" or "Your".

["Maximum Benefit Amount" is the highest dollar amount an Insured can receive for claims incurred for Covered Losses during the Policy period.]

"Medical Emergency" means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury or sickness; 2) prescribed or ordered by a Physician or furnished by a Hospital; 3) performed in the least costly setting required by the Insured's condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Eligible Medical Expense.

"Nurse(s)" means a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN); or, a person licensed in the state in which the nursing or health care service was performed, practicing within the scope of such license.

"Occupational Disease" means an unhealthy condition of the body of an Eligible Person diagnosed by a Provider that is generally accepted as a disease or condition of the body caused solely by exposure to environmental or physical hazards within the Eligible Person's Scope of Employment, and not caused solely, and independently, by an Accident.

"Occupational Injury" means an identifiable physical Injury to, or death of, an Eligible Person caused by an Accident during the Eligible Person's Scope of Employment. Occupational Injury does not include Disease, Occupational Disease, or Cumulative Trauma.

"Occurrence" means an Accident or series of Accidents arising out of one event or incident occurring during the Policy Term in the Eligible Person's Scope of Employment with the Policyholder that result in his or her Occupational Injury. The date of an Occurrence for an Occupational Injury is the date of an Accident or the date of the first in a series of Accidents. The date of an Occurrence for an Occupational Disease or Cumulative Trauma is the date the condition manifests itself and is diagnosed as an Occupational Disease or Cumulative Trauma.

"Other Income Benefits" means any amounts that an Insured or an Insured's dependents receive (or are assumed to receive) under:

- (1) any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
- (2) any benefits provided by the United States Social Security Administration or retirement benefits the Insured receive or any third party receives (or is assumed to receive) on Your behalf or for Your dependents; or, if applicable, that Your dependents receive (or are assumed to receive) because of Your entitlement to such benefits.
- (3) Any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay Our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.

"Payroll" for premium calculation purposes means money or substitutes for money paid by the Policyholder to Eligible Persons for compensation.

"Physician(s)" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to an Insured that is appropriate for the conditions and locality. "Physician" does not include an Insured or a member of the Insured's Immediate Family or household.

"Policy" means this Occupational Accident Policy and any Schedule of Benefits, rider, Group Master Application, notice pages, amendments, and endorsements related thereto.

["Policy Aggregate Limit" is the most We will pay or reimburse for payments made to, or on behalf of, any or all Insureds for all claims incurred for Covered Losses during the Policy period.]

"Pre-Certification" means the Insured has obtained authorization from the claims administrator for non-emergency treatment or services including referral to a specialist prior to incurring Eligible Medical Expenses.

"Pre-existing Condition" means – an illness, disease or other condition of the Insured, that in the 12 month period before the Insured's coverage became effective under the Policy:

- (1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis, care or treatment; or
- (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
- (3) was treated by a Physician or treatment had been recommended by a Physician .

"Provider(s)" means any licensed health care provider or Physician designated by the Policyholder to provide medical treatment for which payment or reimbursement is authorized.

"Scope of Employment" means an activity of any kind or character that has to do with and originates in the Policyholder's work, business, trade or profession, performed by an Eligible Person while engaged in the furtherance of the Policyholder's business. Scope of Employment does not include an Eligible Person's transportation to and from his or her place of employment, unless:

- a. the transportation is furnished as part of the contract of employment, or is paid for by the Policyholder, or the means of transportation is under the Policyholder's control; or
- b. the Eligible Person is directed in the Scope of Employment to precede from one place to another place.

"Temporary Disability" or "Temporarily Disabled" or "Disabled" or "Disability" means an objectively demonstrable physical, anatomical, or physiological abnormality or condition diagnosed by a Provider resulting solely from an Occupational Injury occurring within [thirty (30) days] of the date of an Occurrence that causes an Eligible Person to be unable to obtain and retain employment at wages equivalent to his or her Base Earnings prior to the Occurrence.

"Usual, Customary and Reasonable (UCR) Charge" means the expense is:

- a. usual when it is the fee regularly charged, and the patient's responsibility to pay, in the absence of insurance or other third party reimbursement, by a health care provider or Physician for a given medical procedure, service or supply;
- b. customary in relation to what other Physicians and health care providers in the same geographic area charge for the same procedure service or supply; and
- c. reasonable as a generally accepted medical practice to order the procedure, service or supply for the Eligible Person's Injury or related condition.

"Waiting Period" means the period of time an Eligible Person who becomes Temporarily Disabled while covered under the Policy must be continuously Disabled before Disability Benefits are payable. The Waiting Period is shown in the Schedule of Benefits and begins on the first day of the Temporary Disability.

"We", "Our(s)", "Us" refers to the insurance company (the Company) underwriting the Policy.

ELIGIBILITY FOR INSURANCE

Each person in one of the Covered Classes shown in the Schedule of Benefits is eligible. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

An Eligible Person will be insured on the later of Policy Effective Date or the date he or she is eligible.

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earlier of the date:

1. the Policy Term ends;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. All benefits payable under the Policy are subject to and limited by the Deductible and Combined Single Limit and other terms or limits shown in the Schedule of Benefits.

A. ACCIDENTAL DEATH, DISMEMBERMENT OR LOSS OF USE BENEFITS

If Injury to the Insured results, within [365 days] from the date of a Covered Accident in any one of the Covered Losses shown below, We will pay the Benefit Amount shown below for that Covered Loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all Covered Losses due to the same Covered Accident.

Covered Loss	Benefit Amount
Life.....	[100%] of the Principal Sum
Two or more Members	[100%] of the Principal Sum
One Member.....	[50%] of the Principal Sum
Thumb and Index Finger of the Same Hand	[25%] of the Principal Sum
Four Fingers of the Same Hand	[25%] of the Principal Sum

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing.

"Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent loss of sight of one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent loss of hearing in both ears that is irrecoverable and cannot be corrected by any means. "Loss of a Thumb and Index Finger of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). "Severance" means the complete separation and dismemberment of the part from the body.

"Loss of Use" means the total loss of the ability to perform each and every act and service or function that the Member was able to perform prior to the Occurrence. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted. It must be beyond remedy by surgical or other means.

B. ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Eligible Medical Expenses for treatment of an Occupational Injury that results directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductible, Coinsurance Rate, Benefit Period, Combined Single Limit and other terms or limits shown in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual, Customary and Reasonable Charges incurred after the Deductible has been satisfied; and
2. for those Medically Necessary Eligible Medical Expenses for which the Insured receives Pre-Certification; and
3. provided the first Eligible Medical Expense was incurred within [thirty (30) days] after the date of an Occurrence.

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

Eligible Medical Expenses

1. Medical, surgical, podiatric, optometric, dental, nursing, and physical therapy service provided by or at the direction of a Provider;
2. Chiropractic Care provided it is recommended by a Physician for the treatment of the Eligible Person's Occupational Injury and services are not rendered by the Provider recommending the treatment.
3. Physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a Provider;
4. Services of a Hospital or skilled nursing facility;
5. Prescription drugs, medicines, and other remedies; and
6. Medical and surgical supplies, appliances, braces, artificial members, and prostheses, including training in their use.

Benefits will be payable at a different Coinsurance Rate for Preferred Providers than Non-Preferred Providers as shown in the Schedule of Benefits. The rate will not be less than 80% for a Non-Preferred Provider nor more the 100% for a Preferred Provider. Benefits will be payable at the Preferred Provider rate when the Insured receives services from a Non-preferred Provider that are; a) not available through a Preferred Provider; or b) for a Medical Emergency and the Insured cannot reasonably reach a Preferred Provider. We will continue to pay benefits at the higher rate for a Medical Emergency until the time the Insured can reasonably be expected to safely transfer care to a Preferred Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the rate for a Non-Preferred Provider.

"Preferred Provider" means a licensed Provider of medical services who is under agreement with the Administrator to provide those services.

"Non-Preferred Provider" means a licensed Provider of medical services who is not under agreement with the Administrator to provide those services

C. DISABILITY BENEFITS

We will pay the Disability Benefit shown in the Schedule of Benefits if an Insured is Temporarily Disabled by an Occupational Injury that is a direct result of, and from no other cause but, a Covered Accident. Disability Benefits will begin when:

1. the applicable benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Insured provides satisfactory proof of Temporary Disability to Us, provided the Insured is:
 - a. under the Appropriate Care of a Physician; and

- b. the Temporary Disability begins within [thirty (30) days] after the date of a Covered Accident.

Disability Benefits are payable on a weekly basis for the Weekly Benefit Amount shown in the Schedule of Benefits and subject to the Deductible and Combined Single Limit. Once the Insured is eligible to receive Disability Benefits and is Temporarily Disabled for any period of time equal to less than a full week, we will pay 117th of the weekly Disability Benefit for each day the Insured is Temporarily Disabled.

If the Insured is employed at less than his or her Average Weekly Earnings while he or she remains partially Disabled, the Disability Benefit payable will be reduced by the Insured's taxable earnings during the period.

Benefits will not be paid if the Insured refuses to participate in any medically recommended rehabilitation program or if the Disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Insured has not availed himself or herself of the treatment.

Otherwise, Disability Benefits will end on the first of the following dates:

1. the date the Insured dies; or
2. the date the Insured is no longer Temporarily Disabled; or
3. the date the Disability Benefit Period shown in the Schedule of Benefits ends; or
4. the date the Insured fails to submit satisfactory proof of continuing Disability.

Separate periods of Disability resulting from the same or related causes are a continuous period of Disability unless the Insured can return to Active Service for 14 or more consecutive days. A period of Disability is not continuous if separate periods of Disability result from unrelated causes or the later Disability occurs after coverage under the Policy ends. Benefits will not be payable under the Policy for successive periods of Disability that result from entirely different and unrelated causes unless such periods of Disability are separated by at least one full day during which the Insured is not Disabled and returns to Active Service.

SCOPE OF COVERAGE

AGGREGATE LIMIT. All payments under the Policy will reduce the Policy Aggregate Limit by the amount paid. Our obligation to pay benefits under the Policy shall be limited to the Policy Aggregate Limit, as so reduced, for all Occurrences during the Policy Term.

OTHER INSURANCE. If the Insured is protected against any loss covered by the Policy by any other insurance, indemnity, or reimbursement contract, the Policy shall apply only in excess of the other contract of insurance, indemnity or reimbursement.

DEDUCTIBLE. We will pay benefits only for the amount in excess of the Deductible and up to the limits stated in the Schedule of Benefits. In no event will We be required to pay benefits below the Deductible. We shall have no obligation to reimburse any sum under the Policy until the Deductible amount has been reached.

COORDINATION OF BENEFITS. The Coordination of Benefits (COB) provision is intended to prevent the duplication or overpayment of benefits for Eligible Medical Expenses incurred. It applies when You are also covered by any other certificates or policies. When more than one coverage exists, one certificate normally pays its benefits in full and the other certificate pays a reduced benefit. We will always pay either benefits in full or a reduced amount which, when added to the benefits payable by the other certificate(s) or policies, will not exceed 100% of allowable expenses. Only the amount paid by Us will be charged against Your coverage limits.

Allowable Expenses: means the Usual, Customary and Reasonable Charges for medical and/or dental care or treatment. Part of the expenses must be covered under at least one of the policies.

As Used in this section, 'policy' or 'plan' shall mean:

- coverage under a statutory workers' compensation policy;
- the certificate or the group policy to which it applies;
- any group, blanket or franchise insurance policy or contract;
- a group contractual prepayment or indemnity policy;
- a group Health Maintenance Organization (HMO) contract, whether group practice or individual practice association;
- medical benefits coverage in automobile policies, to the extent permitted by law.

If a policy or plan has two parts and COB rules apply only to one of the two, each of the parts is a separate plan

Our policy is Primary only in the absence of other insurance.

"ORDER OF BENEFIT DETERMINATION"

Our Policy will be primary in all cases except for the following:

1. when any Personal Injury Protection under a No-Fault Automobile Policy is available; or
2. when any coverage is available under the federal Social Security Act or similar law; or
3. when Medicare is primary, or
4. when the Insured qualifies for workers' compensation or any other similar statutory program.

Right to Receive and Release Needed Information – We may, at our sole discretion, give or receive any information that We need to underwrite, investigate and/or settle claims under this Policy. Any person having any information as to a diagnosis, treatment, or prognosis of any physical or mental conditions or nonmedical information about Your family or You is authorized to release such information to Us or Our designee. This includes information related to substance use or abuse. Any medical practitioner, medical facility, pharmacy, the Medical Information Bureau (MIB), employer or insurance company that may have such information is authorized to release such information to Us or Our designee. We or Our claims administrator may also release this information about Your family or You to the MIB or any insurer to which You have applied for coverage or to anyone else it deems necessary to investigate and/or settle a claim under this Policy.

EXCLUSIONS

No reimbursement will be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following:

1. [Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, or any injury that is intentionally caused or aggravated by the Policyholder or an Insured;]
2. [The Insured's participation in: a) a riot or act of civil disturbance; b) an assault or a felony, except an assault committed in the defense of the Policyholder's business or property; c) war or act of war, whether declared or undeclared; or d) service in the military of any country or any civilian non-combatant unit serving with such forces or any loss or damage directly or indirectly occasioned by confiscation, nationalization, requisition, or destruction of, or damage to property by or under the order of any government, public or local authority;]
3. [Terrorism, meaning an act, or acts of any person or group of persons committed for political, religious, ideological or similar purposes with the intention to influence any government or put the public, or any section of the public, in fear. Terrorism can include, but is not limited to, the actual use of force or violence or the threat of such use. Perpetrators of terrorism can be acting alone, or on behalf of, or in connection with, any organization or government;]

4. [Use of: a) nuclear weapons of mass destruction, meaning use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death to people or animals; b) use of chemical weapons of mass destruction meaning the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound that, when suitably distributed, is capable of causing incapacitating disablement or death to people or animals; and c) use of biological weapons of mass destruction meaning the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism or biological produced toxin including genetically modified organisms and chemically synthesized toxins that are capable of causing incapacitating disablement or death to people or animals;]
5. [Liability assumed by the Policyholder under any contract or agreement, including representations, warranties, or indemnities of any kind, except written welfare benefit plans maintained by the Policyholder;]
6. [Travel to or from work, except when a) the transportation is furnished as a part of the contract of employment, or is paid for by the Policyholder, or the means of transportation is under the Policyholder's control; or b) the Insured is directed in his or her Scope of Employment to proceed from one place to another place;]
7. [An act of third person intended to injure the Insured because of personal reasons and not directed at the Insured as an Eligible Person or because of his or her employment with the Policyholder;]
8. [Voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the Insured's Scope of Employment;]
9. [Participation in any activity or hazard not specifically within the Insured's Scope of Employment;]
10. [An act of God, unless employment with the Policyholder exposed the Insured to a greater risk of Injury from an act of God than ordinarily applies to the general public;]
11. [Actual or punitive damages for Injury to an Insured who is employed in violation of law or performing work-related duties in violation of the law;]
12. [Claims arising from work place negligence or employment relationships including, without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, American with Disabilities Act claims, and claims arising under the labor code of any state, and all other claims affecting or arising from the employment relationship whether arising under state or federal statutes or regulations or the common law;]
13. [Liability under the Federal Employer's Liability Act, United States Longshore and Harbor Worker's Compensation Act, the Jones Act or the Migrant Seasonal Agricultural Worker Protection Act;]
14. [Fines, assessments or penalties, pursuant to federal, state, local or other statute;]
15. [Charges incurred by an Insured for which he or she is entitled to receive benefits under any state worker's compensation law, occupational disease law, unemployment compensation disability benefits law, or other similar law;]
16. [Any diagnostic procedure, treatment, service or supply that is not Medically Necessary;]
17. [The part of any charge that is in excess of the Usual, Customary and Reasonable Charge;]
18. [Any Injury occurring while the Insured was legally intoxicated;]
19. [The Insured being under the influence of drugs unless taken under the advice of and as directed by a Physician;]
20. [Treatment by persons employed or retained by the Policyholder, or by any Immediate Family or member of the Insured's household;]
21. [The use of, or exposure to: 1) asbestos, asbestos fibers or asbestos containing products; or 2) the hazardous properties of nuclear material; or 3) silica, silicate dust; or 4) radon; or 5) lead; or 6) mercury; or 7) mold, fungus, mildew, yeast or microbial contamination;]
22. [All statutory causes of action including, but not limited to, Title VII Civil Rights Act of 1964, Civil Rights Act of 1991, Civil Rights Act of 1866, Age Discrimination In Employment Act, Employee Retirement Income Security Act (except for plan benefits awarded under actions brought pursuant to §502(a)(1)(9B) of ERISA, 29 U.S.C. §1132(a)(1)(B), Fair Labor Standards Act, Bankruptcy Code, Texas Commission on Human Rights, Texas Workers' Compensation Act, Railway Labor Act and National Labor Relations Act;]
23. [The following common law causes of action alleged against the Policyholder by an Insured: a) claims under any contract of employment whether written, oral or implied; b) a breach of duty of good faith and

- fair dealing; c) breach of non-competition agreements; d) claims for tortious interference with contractual relations; e) intentional or negligent infliction of emotional distress; and f) claims based on assault and battery, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation and fraud, false imprisonment, false arrest, malicious prosecution, unreasonable search, and retaliatory discharge;]
24. [Any payments that were made by the Policyholder due to the failure by the Policyholder to properly comply with the statutory requirements to become a nonsubscriber in the workers' compensation system;]
 25. [Any obligation imposed by a worker's compensation, occupational disease, unemployment compensation, disability benefits or similar law and any expenses or fees incurred by the Policyholder defending such obligations;]
 26. [Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound during the Insured's Scope of Employment, independent and in the absence of any underlying sickness, disease or condition including, but not limited to, diabetes;]
 27. [Travel or flight in or on (including getting in or out of, or on or off of) an airplane, helicopter or any other device used for aerial navigation, if the Insured is: a) flying in an aircraft that is rocket propelled; b) flying in any aircraft used for aerobatics, racing or endurance test, crop dusting or seeding or fertilizing or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing, skydiving or skywriting or any test or experimental usage; c) flying when a special permit or waiver from the proper authority has to be issued; d) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; e) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; f) riding as a passenger in an aircraft owned, leased or operated by the Policyholder;]
 28. [Any Pre-existing Condition;]
 29. [Occupational Disease, unless otherwise covered under a Rider to the Policy;]
 30. [Cumulative Trauma, unless otherwise covered under a Rider to the Policy;]
 31. [Osteoarthritis, arthritis, or any other degenerative process of the joints, bones, tendons or ligaments;]
 32. [Mental trauma and mental, nervous, emotional or psychological conditions or disorders;]
 33. [The medical or surgical treatment of sickness, Disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment;]
 34. [Stroke or cardiovascular event or accident; myocardial infarction or heart attack; coronary thrombosis; aneurysm;]
 35. [Any claim otherwise covered by the Policy, whether known or unknown, that is not reported to Us within twelve (12) months from the end of the Policy Term.]

ADMINISTRATIVE PROVISIONS

Premium. Premium shall be paid in monthly, quarterly, semiannual, or annual installments, as shown on the Schedule of Benefits, with a deposit premium due with the Policyholder's Group Master Application. We have the right, during the Policy Term and for a period of three years thereafter, to audit the Policyholder's Payroll and assess and review the Policyholder's records to determine the correct amount of Premium due under the Policy.

The amount of each premium payment is the sum of the products of:

- a. the Payroll of all Eligible Persons within each of the occupational class code(s) at the beginning of each reporting term during the Policy Term; and
- b. the premium rate for the respective occupational class code(s) as determined by Us at the beginning of the Policy Term.

Changes In Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written notice by facsimile, electronic mail or regular mail. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than

once in a 12 month period; except, We reserve the right to change rates at any time if any of the following events take place:

1. The terms of the Policy change;
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy;
3. There is a change in the factors bearing on the risk assumed; or
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

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

Cancellation. The Policyholder may cancel the Policy at any time by written notice to Us. We may cancel the Policy at any time for any of the following reasons:

- a. Policyholder fraud in obtaining this coverage;
- b. failure to pay any Premium or other sum under the Policy when due;
- c. an increase in workplace hazards within the Policyholder's control that would produce an increase in premium rate.

We may cancel the Policy by delivering or mailing to the Policyholder, by registered, certified, or first class mail, at its last known address, written notice of cancellation stating the reason for cancellation and stating when, not less than 30 days thereafter, the cancellation shall be effective, except for non-payment of any installment or additional amount of Premium. If the Policyholder fails to pay any Premium when due, the written notice shall state a date when the cancellation is effective.

If the period of limitation relating to the giving of notice is prohibited or made void by any controlling law, such period will be deemed amended so as to be equal to the minimum period of limitation permitted by such law. If the Policy is canceled by the Policyholder, We will retain the pro rata portion of the Premium or the deposit premium, whichever is larger.

If the Policy is canceled, We will retain the pro-rata proportion of the Premium determined by the Premium Percentage of Payroll. A statement of actual Premium due will be rendered after the Policy expiration date, and if the Premium earned is greater or less than the Premium actually paid for the Policy Term, then such additional, or returned, Premium will be due and payable within 30 days.

We may refuse to renew the Policy by delivering or mailing to the Policyholder, by registered, certified, or first class mail, at its last known address, not less than 30 days prior to the expiration of the Policy Term, written notice of non-renewal, stating the reason for non-renewal. Coverage will remain in effect until the 31st day after the date on which the notice is delivered or mailed.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Access To Books And Records. The Policyholder's books and records, and those books and records of any agents and representatives, any loss control or risk management, and third party administrator, shall be open for inspection by Us and Our representatives at all times during usual business hours during the Policy Term and for three years thereafter. We or Our representatives may audit any and all such books and records, and make and take away copies thereof, relating to the Policy, claims hereunder, Payroll and Premium.

CLAIMS ADMINISTRATION

Claim Handling. We, or a claims administrator appointed by Us, will, subject to the conditions contained

herein, investigate and adjust any claim under the Policy made against the Policyholder arising from any Occurrence. The Policyholder shall cooperate fully and, upon request, supply such information as may be required in order to adjust the claim. The Policyholder's failure to exercise diligence, prudence and good faith, or its willful mishandling or mis-administration of any claim may result in forfeiture of coverage for the claim.

No investigator, adjuster, or counsel shall be employed to represent Our interest without Our prior written approval. We reserve the right to obtain other professional services at Our expense, as We deem necessary. The Policyholder shall not make any payment nor incur any obligation to pay any sum other than pursuant to the terms of the Policy.

Medical Cost Review Requirement. As a condition precedent to payment of claims under the Policy, the Policyholder agrees to implement, and the Employee and the Policyholder agree to follow, medical care cost containment procedures as may be recommended by a third party medical cost containment service selected by Us.

Physical Examination and Autopsy. We, at Our own expense, have the right to have an Insured examined when and as often as reasonably necessary while a claim is pending. Failure to submit to the examination will result in forfeiture of coverage relating to the Insured. We also can have an autopsy performed, at Our expense, unless prohibited by law.

Commutation Clause. All claims under the Policy, if any, may at Our option, be commuted [24-84] months after the end of the Policy Term. The Policyholder will submit a list of all claims under the Policy 30 days prior to the commutation date. The claim listing the Policyholder provides must include all pertinent information necessary to arrive at valuation of all claims. The claim listing the Policyholder provides will be submitted to an actuary or appraiser mutually acceptable to both the Policyholder and the Company to determine the discounted net worth of all claims. If the actuary or appraiser cannot be agreed upon by both the Policyholder and Us, each will appoint its own actuary or appraiser who will, in turn, appoint an independent actuary or appraiser who will establish the discounted net worth of each claim. We will pay the Policyholder the discounted net worth of each claim that is in excess of the Deductible, subject to the Combined Single Limit, within 30 days of receipt from the actuary or appraiser. Payment to the Policyholder in accordance with this paragraph will achieve a complete settlement and discharge of all present or future, known or unknown, claims under the Policy.

Assignment. The Policy is not assignable unless We consent in writing to its assignment. An interest in death benefits is assignable but no assignment of death benefits is effective until an original assignment and any other requested documents are received by Us. We assume no responsibility for the validity of any such assignment.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the forfeiture of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Payment Of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary Our records indicate the Insured designated for these plan benefits. If no named beneficiary or surviving beneficiary is on record with Us or Our authorized agent, death proceeds will be paid to the beneficiary the Insured has designated under the Policy issued to the Policyholder and in effect at the time of the Insured's death.

If there is no named beneficiary or surviving beneficiary on record with Us or Our authorized agent, We pay benefits in equal shares to the first surviving class of the following:

1. spouse;
2. children;
3. parents;

4. brothers and sisters.

If there are no survivors in any of these classes, We will pay the Insured's estate.

All other benefits will be paid to the Insured. If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a spouse, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written notice. A Beneficiary has no interest in the policy other than to receive the benefits for loss of life. The Insured may change the beneficiary at any time unless his or her interest has been assigned. Unless there has been an assignment, consent to change by a prior beneficiary is not needed.

The name of the beneficiary is not effective until entered on the records of the Policyholder. We are not responsible for the correctness of the records.

If the covered person is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

NOTICE OF CLAIM AND LOSS REPORTS

The Policyholder agrees to give written notice to Us, or as directed by Us, as soon as reasonably practicable, of each Occurrence that may give rise to a claim under the Policy and of each subsequent development that is related to the claim.

Written notice of claim must be given to Us within 30 days after the date of the Occurrence for any Occurrence involving any of the following:

1. Disability for a period of seven days or more;
2. spinal cord Injury;
3. severe burn Injury;
4. brain Injury;
5. Injury of two or more Insureds from a single Accident;
6. death of an Insured;
7. any lawsuit or other proceeding claiming damages involving an Occurrence;
8. multiple trauma; or
9. motor vehicle Accident.

Notice given to Us or to any authorized agent of Ours, with information sufficient to identify the Policyholder and the Insured(s), and contained on forms supplied by Us, shall be deemed notice to Us.

The Policyholder will give immediate notice to Us, including copies, upon receipt, of each lawsuit served or written demand made upon the Policyholder by any Insured or any attorney representing an Insured, irrespective of the amount claimed.

Within fifteen (15) days after receipt of written notice of claim from the Policyholder, We will furnish claim forms to the Policyholder, and request from the Policyholder, all items, statements, and forms that We reasonably believe, at that time, will be required from the Policyholder. Additional requests may be made during the investigation of the claim. If claim forms are not furnished, the Policyholder will be considered to have met the requirements for written proof of loss if the Policyholder delivers written proof of the loss to Us, including a description of the Occurrence, and the extent, date, and nature of the loss.

Written proof of loss must be delivered to Us within 30 days after the date of such loss. If it is not reasonably possible to deliver the proof within 30 days, the claim is not affected if the proof is delivered to Us as soon as possible; however, such proof must be delivered within 365 days of the date of loss.

Settlement. The Policyholder agrees not to make any voluntary settlements involving payments by Us. We have all rights to adjust and settle claims for benefits under the Policy in excess of the Deductible. If the Policyholder refuses to consent to any claims settlement demanded by the claimant and recommended by Us (the "claims settlement amount"), but instead elects to contest a claim or to continue litigation at the trial level or at the appellate level in connection with such claim, then Our obligation under the Policy for such claim will not exceed the difference between the Deductible and the lesser of the claims settlement amount or the remaining Combined Single Limit. We may discharge all obligation under the Policy on account of any such claim or suit by paying the difference between the Deductible and the lesser of the claims settlement amount or the remaining Combined Single Limit. The Policyholder releases Us from any further liability for such claim upon Our payment as outlined above.

Subrogation. If payment is made under the Policy, We will be subrogated to all of the Insured's rights of recovery, and all such rights of any person receiving monies provided or paid by the Policy, against any person or organization except the Policyholder and its affiliates; and the Insured agrees to execute and deliver instruments and do whatever else is necessary to secure Our subrogation rights. Neither the Policyholder or the Insured will do anything to prejudice Our subrogation rights, without Our prior written consent.

Sunset Clause. We will cover claims based upon Occurrences described in the Policy occurring during the Policy Term provided that, and only in so far as, such claims and Occurrences are reported to Us within 12 months after expiration of the Policy Term. Claims reported to Us after such date are not eligible for payment under the Policy.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements, riders or amendments) and the signed Group Master Application of the Policyholder are the entire contract. Any statements made by the Policyholder or Insureds will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application given to the Policyholder.

To be valid, any change or waiver must be in writing it must be signed by Our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Incontestability. The validity of this Policy will not be contested after it has been in force for [two] year(s) from the Policy Effective Date, except as to nonpayment of premiums.

Any statements made in the Group Master Application are representations and not warranties. No statement will be used to contest coverage under the Policy unless such statement is contained in a written instrument and a copy is given to the Policyholder.'

Clerical Error: If a clerical error is made, it will not affect the insurance of any Insured. No error will continue the insurance of an Insured beyond the date it should end under the Policy terms.

Conformity With State Laws: On the effective date of this Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

Legal Actions: No lawsuit or action in equity can be brought to recover on this Policy: (1) before 60 days following the date proof of loss was given to Us; or (2) after 3 years following the date proof of loss is required.

Misstatement of Age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverage or amount of benefits or both shall be adjusted in accordance with the Insured's true age. We may require satisfactory proof of age before paying any claim.

Policyholder Not Company's Agent. The Policyholder shall in no event be considered Our agent for purposes of the Policy or any other purpose.

Inspection and Safety. For Our sole and exclusive benefit, an underwriting inspection by Our designated safety engineer, or safety inspector, will be permitted at all of the Policyholder's workplace(s), with or without notice, during the Policyholder's regular business hours.

As a condition precedent to the Policyholder's right to payments on behalf of an Eligible Person under the Policy, the Policyholder warrants that it will keep in place the safety procedures and/or loss control engineering services and/or safety consultants and/or claims administration procedures and/or claims consultants and/or third party administrators that it disclosed to Us on its Group Master Application, when and where requested. Notice of any proposed amendment to the specific procedures, personnel, and/or services must be provided to Us. The Policyholder agrees that We have the right to inspect, through Our authorized representatives, at any reasonable time, its books, records and premises to verify that it has kept these procedures, personnel, and/or services in place, as represented.

Action Against Us. No action by the Policyholder will lie against Us unless, as a condition precedent thereto, it has fully complied with all the terms of the Policy, and until the amount of any obligation to pay damages arising from any Occurrence shall have been finally determined either by judgment against the Policyholder after actual trial or by written arms-length agreement between the Policyholder and the Eligible Person claimant, and only after payment has been made by the Policyholder in full satisfaction of all expenses in connection with the Occurrence. Nothing contained in the Policy shall give any person or organization any right to join Us as a co-defendant in any action against the Policyholder to determine the Policyholder's liability for any Occurrence.

Binding Arbitration. In the event of any dispute, controversy or claim between the parties to the Policy, including their officers, directors, Eligible Persons, owners, heirs, assigns, affiliates, reinsurers, or agents, related to or arising out of the matters covered by this agreement or its breach, such dispute, controversy, or claim will be finally settled by binding arbitration pursuant to the procedures set forth in this arbitration provision. The scope of this arbitration provision includes but is not limited to performance of the respective obligations of the parties under the Policy, any questions of interpretation of any article, clause, or other provision of the Policy, any claim for breach of the duty of good faith and fair dealing, breach of contract, or any claim for violation of any state, federal, or governmental law, statute, regulation or ordinance including, but not limited to, the Texas Deceptive Trade Practices Act and the Texas Insurance Code. The parties agree that the insurance provided by the Policy involves commerce among multiple states, and therefore the Federal Arbitration Act and related federal procedure will govern arbitration as set forth in this provision to the fullest extent possible and state arbitration law will not apply.

This arbitration will be governed by the Commercial Arbitration Rules of the American Arbitration Association unless specifically varied by the terms stated in this arbitration provision. Either party may make a written demand for arbitration, setting forth the nature of the dispute and naming an arbitrator with a minimum of 10 years' experience in the insurance industry, by registered or certified mail, return receipt requested. Notice to the Policyholder will be sent to the address furnished by the Policyholder in its Group Master Application for coverage, unless We have received written notice of an address change from the Policyholder. Notice to Us will be sent to Us at the Company address.

When a demand is made, the noticed party will have 30 days to respond and name a second arbitrator. If the noticed party does not respond by naming a second arbitrator within 30 days, the arbitrator named by the demanding party will be the sole arbitrator to hear the dispute. If the remaining party responds within the 30 days by naming a second arbitrator, the two arbitrators will select a third arbitrator with a minimum of ten years' experience in the insurance industry. Each party will pay the cost of its own arbitrator if a panel is selected consisting of two party arbitrators and an umpire. The parties shall share equally in the cost of an umpire and/or third arbitrator. If the two arbitrators cannot agree upon a third arbitrator within 30 days, either may request that the selection of the third arbitrator be made by the Dallas, Texas office of the American Arbitration Association. A decision agreed to by two arbitrators will be binding.

The parties agree that the Policy is to be performed in Dallas, Texas. Unless both parties agree otherwise, arbitration will take place in Dallas, Texas. Arbitration will be conducted by written submission unless either party requests a live hearing before the arbitrator(s) at least 10 days prior to the due date for the written submission. Discovery will be limited to the exchange of documents. If there is to be a hearing, each side additionally will submit to the panel and the other party a detailed position brief, one week prior to the hearing, to include disclosure of witnesses to be called at the hearing. Affidavits of witnesses not testifying at a hearing will not be admitted.

The arbitrator(s) will not be bound by federal, state, or local rules of evidence or procedure, other than as set forth by the Federal Arbitration Act, and will apply the substantive law of the State of Texas or the industry standard or practice relating to the issue under consideration. Failure to correctly apply Texas substantive law because industry standard or practice was applied in lieu thereof, will neither void the arbitration award nor provide grounds to appeal to a court to vacate the award. The arbitrator(s) will deliver a decision stating only the arbitrators' ultimate determination within 30 days after a hearing on the issues or the written submission, and payment of any amounts awarded to either party will be due within 30 days after the issuance of the award, after that time interest on the award will accrue from the date the award was issued at a rate of 8% per annum until the award is finally paid. Any decision or award resulting from any arbitration proceeding will include assessment of costs, expenses and reasonable attorneys' fees. Judgment on the award rendered by the arbitrators, including any post-award interest, may be entered in any Court having jurisdiction thereof, and any costs of obtaining or collecting on the judgment, including reasonable attorneys' fees, will be assessed against the party against whom the judgment is filed and granted. Arbitrators will be limited to the award of actual or compensatory damages and costs only (including consequential damages), and will not be permitted to award punitive or exemplary damages against either party.

This arbitration provision will not be construed to deny any court having jurisdiction the power to award, in appropriate circumstance, interim relief pending arbitration, including, but not limited to, temporary restraining orders and injunctions, provided that it is not feasible for the arbitrators to consider such relief rapidly enough to prevent serious harm to the party seeking the relief and, provided further, that the arbitrators have not already considered such relief and refused to allow it. Notwithstanding the need for interim relief, if any party to the Policy pursues a claim covered by this arbitration provision by litigation rather than arbitration, the responding party will be entitled to the dismissal of such action along with the recovery of all cost, attorneys' fees, and actual losses directly related to such action.

This arbitration clause will survive the expiration or other termination of the Policy.

Not in Lieu of Workers' Compensation: The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

ACCEPTANCE OF POLICY

The Group Master Application, the Policy form, the Schedule of Benefits, notice pages, amendments, riders and all endorsements form the terms, conditions, exclusions, representations, and warranties of the Policy.

By accepting the Policy, the Policyholder agrees that the statements in the Group Master Application and the Schedule of Benefits are the Policyholder's own representations; that the Policy is issued in reliance upon these representations; that the Policy embodies all agreements existing between the Policyholder and Us or any of Our agents, relating to this insurance; and, that full compliance by the Policyholder with all terms of the Policy is a condition precedent to Our obligation to pay benefits under the Policy.

No change in the Policy is valid unless approved in writing by Us. Only Our President or Secretary may agree to alter the Policy and only by rider, endorsement or amendment in writing. No agent has the authority to change the Policy or to waive any of its provisions.