



Starr Indemnity & Liability Company

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

Occupational Accident Insurance Policy (“Policy”)

POLICYHOLDER: [ABC Employer]

POLICY NUMBER: [123456]

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.]

PREMIUM DUE DATE: [1st of each month]

STATE OF DELIVERY: Texas

In return for the payment of the required premium, We agree to indemnify Policyholder for the benefits detailed in the Policy subject to the terms and conditions set forth herein. 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 upon terms. The Policy terminates at 12:01 A.M. Standard Time at the address of the Policyholder on the last day of the Policy Term unless Policyholder and We agree, in writing, to continue coverage under this Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premium is paid on or before the Premium Due Date shown above, 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 THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS’ COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS’ COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS WHICH 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: ConsumerProtection@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 al

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 entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA

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

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Claims Administrator

[Texas Healthcare Foundation, L.P.

Telephone: 800-716-6777 (24 hours/7days a week)

Fax: 972-317-0889

Website: www.texashealthcarefnd.com]

INSURANCE SECTION

This Policy insures the [Employer's Name] Employee Occupational Injury Benefit Plan (the "Plan") attached to this Policy as an integral part of the Application for Occupational Accident Insurance. The terms of this Policy may not be changed or waived, except by written amendment or endorsement signed by Our President or General Counsel and made part of this Policy.

No other organization newly acquired, incorporated or developed by the Policyholder shall be a Policyholder unless accepted by Our President or General Counsel in writing.

DESCRIPTION OF BENEFITS

This Policy reimburses for a Claims Loss only to the extent provided in this Policy. No Claims Loss will be reimbursed for any expenses incurred that are not paid in accordance with the terms and conditions of the Plan, or are eligible for payment or reimbursement under any other plan or insurance policy. The Policyholder may make changes to the Plan, but unless each change is prospectively sent to and accepted in writing by Us, this Policy will apply as if the change had not been made. We have the right to amend any item on the Schedule of Benefits as of the effective date We accept the change. We will reimburse the Policyholder for the amount of a Claims Loss paid in excess of the Deductible shown in the Schedule of Benefits, but not for more than the Limits of Liability shown in the Schedule of Benefits. The amount reimbursed for a Claims Loss is subject to and will accumulate towards the Limits of Liability.

This insurance covers Claims Losses paid by the Policyholder under the Plan which occurs during the period this Policy is in force.

We maintain the right to investigate eligibility status and attendance records to verify if a Plan Participant is eligible for benefits under the Plan. If We discover a Plan Participant is not eligible for benefits under the Plan, Our only obligation is to refund any premium paid for that Plan Participant.

Policyholder is the Plan Sponsor and warrants it has adopted the Plan and the Dispute Resolution Plan (also attached to the Master Application for Occupational Accident Insurance) as a condition of this Policy.

POLICYHOLDER'S DEDUCTIBLE AND OUR LIMITS OF LIABILITY

Policyholder shall retain and pay for its own account without the benefit of other insurance all Claims Losses up to the Deductible shown in the Schedule of Benefits.

The Limit of Liability for Annual Policy Aggregate shown in the Schedule of Benefits is the maximum We will pay for Claims Losses, regardless of the amount of Claims Losses paid by Policyholder.

The Limits of Liability apply separately to each consecutive annual period and to any remaining period of less than 12 months, starting with the beginning of the Policy Term shown in the Schedule of Benefits, unless the Policy is extended after issuance for an additional period of less than 12 months. In that case, the additional period will be deemed part of the last preceding period for purposes of determining the Limits of Liability.

We may reduce the amount of payments applied to the Deductible if We determine they are in excess of Fair and Reasonable Reimbursement. In no event will We be required to pay a Claims Loss below the Deductible. We shall have no obligation to pay for or to reimburse any sum under the Policy until and unless the Deductible is satisfied by the Policyholder.

If the Policyholder or the Plan Participant is protected by any other insurance, indemnity, or reimbursement contract against any Claims Loss covered by this Policy, this Policy shall apply only in excess of the other contract of insurance, indemnity or reimbursement.

The inclusion of more than one organization as a Policyholder shown in the Schedule of Benefits will not increase Our Limits of Liability shown in the Schedule of Benefits.

EXCLUSIONS

No payment or reimbursement will be made for any Claims Loss resulting in whole or in part from, or contributed to or aggravated by, any of the non-covered items identified in the Plan or any Claims Loss otherwise covered by the Plan, whether known or unknown, that is not reported to Us within 3 months from the end of the Policy Term. The Policy indemnifies for Plan Benefits only to the extent provided in the Plan and does not insure any casualty or general liability risk of the Policyholder. The Policy does not indemnify the Policyholder for any losses, damages or awards to Employees from a finding of negligence or otherwise for accidental injury or death except in accordance with the terms and conditions in the Amendment for Employer Indemnity Coverage if such coverage is made part of the Policy.

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 Application. The premium for this Policy will be based on the rates currently in force for the amount of insurance in effect and is subject to verification by inspection or audit. The rates per Covered Class used to calculate the premium are shown in the Schedule of Benefits. The premium may change to reflect changes in coverage, Payroll and the number of the Policyholder's Plan Participants for each Covered Class identified in the Schedule of Benefits.

Earned Premium: The earned premium will be determined at the end of the Policy Term by use of the actual, instead of estimated, premium base. Policyholder will pay within 60 days such excess to Us. If such earned premium is less than previously paid, We will return the balance to Policyholder within 60 days.

Payment of Premium: The first Premium is due on the Policy Effective Date. After that, premiums will be due [monthly] unless We agree in writing on some other method of payment. If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

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 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. Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

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 often than once in a 12 month period. However, We reserve the right to change rates at any time and at Our sole discretion or judgment if any of the following events take place:

1. The terms of this Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from this Policy.
3. Market factors bearing on the risk assumed in this Policy change.
4. Any federal or state law or regulation is adopted or amended to the extent it affects Our insurance obligation.
5. The risk or exposure assumed under this Policy change.

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.

Incorrect Premium Payment: Premiums paid in error, for a Plan Participant who is not covered, will be refunded. Such refunds are without interest and must be requested by Policyholder in writing. Except for fraud, premium adjustments or refunds will be made only for the current and the prior Policy Term.

Policy Termination Date: We may terminate this Policy by giving 31 days advanced notice in writing to Policyholder. Either We or the first named Policyholder shown in the Schedule of Benefits may terminate this Policy on any Premium Due Date by giving 31 days advance written notice to the other party. This Policy may be terminated at any time by mutual written consent of Policyholder and Us. This Policy terminates automatically: 1) at the end of the Policy Term; or 2) the Premium due date if Premiums are not paid when due; or 3) the date the Plan terminates, whichever occurs first. Termination takes effect at 12:01 A.M. Standard Time at the Policyholder's address on the date of termination.

Access To Books, Records and Data: The Policyholder's books, records and data, and those books, records and other information of any Policyholder's agents, attorneys, and representatives, loss control or risk managers, and third party administrator relating to the subject matter of this Policy, shall be available for inspection by Us and Our representatives at all times during usual business hours during the Policy Term, and for 3 years after the Policy terminates. We or Our representatives may audit, make and take away copies of any and all such books, records and other information relating to the premiums or any subject matter of this Policy.

CLAIM PROVISIONS

Claims Administrator: The Claims Administrator shown in the Schedule of Benefits is appointed by Us to investigate, pay, settle and appeal any claim made against the Policyholder for a Claims Loss covered by this Policy. Policyholder must cooperate fully with Us and the Claims Administrator, and supply such information as requested to process a Claims Loss. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether a Claims Loss is payable pursuant to the Plan. Failure of a Policyholder to cooperate with Us in the administration of a claim will result in the denial and non-payment of the Claims Loss. Failure by Policyholder to exercise diligence or its mishandling of any claim may also result in non-payment of the Claims Loss.

No investigator, adjuster, or counsel may be employed to represent Our interest without Our prior written approval. We reserve the right to obtain other professional services at our own expense as We deem necessary. Policyholder shall not make any payment nor incur any obligation to pay any amount regarding any claim under the Policy without Our prior written approval.

Notice of Claim: Policyholder must give the Claims Administrator immediate notice (within 24 hours) at its telephone number listed in the Schedule of Benefits when Policyholder becomes aware of any Occupational Injury sustained by a Plan Participant. The Claims Administrator will then assist the Policyholder in documenting the Occupational Accident as well as coordinating Medical Care for the Plan Participant(s).

Notwithstanding the above, **written notice of all Occupational Injuries must be given to the Claims Administrator within 30 days after the date of the Occurrence that resulted in an Occupational Injury.** Notice given to Us, the Claims Administrator or to any authorized agent of Ours, with information contained on forms supplied by Us sufficient to identify Policyholder and the Plan Participant(s) shall be deemed notice to Us.

Notice of Plan Benefit Denials, Terminations, Suspensions and/or any Legal Involvements: We must be notified in writing within 48 hours when any benefits under the Plan otherwise due a Plan Participant has been denied, terminated or suspended. The Policyholder will also give immediate notice to Us, including copies, upon receipt, of each lawsuit served or written demand made upon a Policyholder by any Plan Participant or any attorney representing a Plan Participant relating to a Claims Loss covered by the Policy, irrespective of the amount claimed.

Claim Forms: Upon receiving written notice of a Claims Loss, We or the Claims Administrator will provide the Policyholder with the claim forms necessary to complete. If such claim forms are not furnished, the Policyholder will satisfy the requirements of written proof of Claims Loss by sending the written proof as stated in the Proof of Claims Loss below. The proof must describe the nature of the injury claimed by a Plan Participant and the extent of the Claims Loss.

Proof of Claims Loss: Written proof of Claims Loss must be sent to the Claims Administrator within 30 days after the date of the Claims Loss.

Payment of Claims: Subject to the Deductible and Limits of Liability shown in the Schedule of Benefits, payment for any Claims Loss is payable within 30 days of the date We receive proper proof of Claims Loss.

Physical Examinations and Autopsy: We have the right to have a healthcare provider of Our choice examine a Plan Participant as often as is reasonably necessary. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the above noted examination(s) or autopsy requested by Us.

Cost Containment Requirement: The Policyholder is required to implement and follow Medical Care cost containment procedures as may be recommended by Our Claims Administrator prior to the payment of any claim for benefits under the Plan, whether applied to satisfy the Deductible, or a payable or reimbursable claim against Our liability.

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 Deductible is not paid by the Policyholder, We have no obligations whatsoever under the Policy. If the Policyholder refuses to consent to any claims settlement demanded by a Plan Participant and recommended by Us (hereinafter 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 obligations 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 Policyholder and/or the Plan Participant's rights of recovery, and all such rights of any person(s) receiving monies provided or paid by the Policy, against any person(s) or organization except Policyholder and its affiliates, and Policyholder and/or the Plan Participant agrees to execute and deliver instruments and do whatever else is necessary to secure Our subrogation rights. Neither the Policyholder nor the Plan Participant will do anything to prejudice Our subrogation rights without Our prior written consent.

Sunset Clause: We will cover the Claims Losses described in the Policy occurring during the Policy Term if, and only to the extent that such Claims Losses are reported to Us within 12 months from the date the Policy Term ends. Claims Losses reported after such date, even if Policyholder only becomes aware of the Claims Loss after such date, are not eligible for reimbursement under the Policy.

Commutation Clause: All claims reported under the Policy, if any, may at Our option, be commuted [24-84] months after the end of the Policy Term. The Policyholder must submit a list of all claims under the Policy 30 days prior to the commutation date. The claim listing provided by the Policyholder must include all pertinent information necessary to arrive at a valuation of all claims. The claim listing the Policyholder provides will also be submitted to an actuary or appraiser mutually acceptable to both Policyholder and Us 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 Policyholder the discounted net worth of each claim that is in excess of the Deductible, subject to our Limit of Liability, 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 this Policy.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including the Binder, the Schedule of Benefits and any endorsements, riders or amendments), the Application for Occupational Accident Insurance and all its attachments signed by or on behalf of the Policyholder are the entire contract.

We may, upon 31 days written notice to Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of any state or federal law or regulation. Changes to this Policy may be made without the approval of the Policyholder.

To be valid, any change or waiver must be in writing, signed by Our President or General Counsel and attached to this Policy. No agent has authority to change or waive any part of the Policy. We will not be bound by any promise or representation made by or to any agent or person other than the President or General Counsel of the Company.

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 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 the Policyholder. No error will continue the insurance beyond the date it should end under the Policy terms.

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

Sole Representative: If more than one Policyholder is named on the Schedule of Benefits, the first named Policyholder will act on behalf of all Policyholders to give or receive notice of cancellation, receive return premium or indemnity payments, or request changes to this Policy.

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

Not In Lieu of Workers' Compensation: This Policy is not a Workers' Compensation policy, and therefore does not provide any Workers' Compensation benefits to Plan Participants under the Plan.

Other Insurance: If any other insurance, indemnity, reimbursement agreement or self-insurance exists protecting Policyholder or the Plan Participant against loss or have paid for any loss that may otherwise be covered by this insurance, this insurance shall apply in excess of the other insurance, indemnity, reimbursement agreement or self-insurance. This does not apply to any excess insurance, indemnity,

reimbursement agreement or self-insurance specifically purchased or structured by Policyholder to apply above our Limits of Liability.

Inspection: We have the right, but not the duty, to request inspection of Policyholder's operations and workplaces. In the event of a request for inspection, Policyholder agrees, by acceptance of this Policy, to secure, at its sole expense, a loss control inspection by an inspection company selected by Us, within 30 days of such request. Such inspections are not safety inspections. They relate only to the insurability of the workplace and the premium to be charged. We may give reports to the Policyholder on the conditions found upon inspections. By making an inspection, We do not undertake to provide for the health or safety of Plan Participants or the public, nor do We warrant that Policyholder's workplaces are safe or healthful or that they comply with any law, regulation, code or standard, nor are We responsible for any penalties or fines incurred as the result of any violation of such laws, regulations, codes or standards.

Assignment: An assignment of interest under this Policy will not bind Us unless an endorsement is agreed to in writing by the President or General Counsel of the Company.

Bankruptcy or Insolvency: Policyholder's bankruptcy, insolvency or inability to pay the Deductible relieves Us from any and all reimbursement or payment obligations under this Policy or duty to defend.

Binding Arbitration: In the event of any dispute, controversy or claim between the parties to the Policy, including their officers, directors, employees, Plan Participants, 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 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.

DEFINITIONS

Certain capitalized words and phrases used within this Policy have specific meanings. The definition of any capitalized word or phrase, if not defined in the text where used, may be found in either the Definitions section of the Plan or this Policy, 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.

“Claims Loss” means only those [Medical Benefits, Wage Replacement Benefits, Accidental Dismemberment Benefits and Accidental Death Benefits] actually paid by the Policyholder in accordance with the terms and conditions of the Plan.

["Combined Single Limit Per Occurrence"] is the highest dollar amount We will reimburse for the amounts paid to or on behalf of all Plan Participants who suffer injuries as a result of any one claim for Claims Losses.]

["Combined Single Limit Per Plan Participant"] is the highest dollar amount We will reimburse for payments made to any one of the Plan Participants whether payments or reimbursements are made under one or more of the benefits provided by this Policy for any one claim for Claims Losses.]

“Covered Accident” means an Occupational Accident that occurs during the Policy Term while coverage is in force for a Plan Participant.

“Covered Class” means a class of Policyholder’s Plan Participants defined as eligible under the Policy. Covered Classes are shown in the Schedule of Benefits.

“Deductible” means the amount as shown in the Schedule of Benefits which the Policyholder must pay before We will reimburse for any Claims Loss. If the Policyholder does not pay the Deductible for any reason, We have no obligation to pay under the Policy.

["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.]

["Maximum Benefit Amount” is the highest dollar amount a Plan Participant can receive for claims incurred for Claims Losses during the Policy period.]

“Occupational Accident” means an Accident that occurs during the Policy Term while coverage is in force and arose within the Plan Participant’s Scope of Employment.

“Occurrence” means an Occupational Accident or series of Occupational Accidents arising out of one event which results in an Occupational Injury to one or more Plan Participants.

“Payroll” for premium calculation purposes means money or substitutes for money paid by the Policyholder to Plan Participants, for compensation.

“Plan Participant” means an Employee who satisfies all eligibility requirements for participation in the Plan, and who has made a claim for, received or accepted any benefit under the Plan.

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

“Policyholder” means the Employer shown in the Schedule of Benefits, including any organization that has adopted the [Employer’s Name] Employee Occupational Injury Benefit Plan and also listed in the Schedule of Benefits.

“We”, “Our(s)”, “Us” means Starr Indemnity & Liability Company underwriting the Policy.