

EXCLUSIONS AND LIMITATIONS

A loss is not covered if it results from suicide or attempted suicide, while sane or insane; intentionally self-inflicted injuries, or any attempt to inflict such injuries; Sickness, whether the loss results directly or indirectly from the sickness; Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment; any bacterial or viral infection. But, this does not include: a pyogenic infection resulting from an accidental cut or wound; or a bacterial infection resulting from accidental ingestion of a contaminated substance; taking part in any insurrection; War, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression; an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training; commission of or attempt to commit an assault or a felony; travel or flight in any vehicle used for aerial navigation, if: the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; the person is performing as a pilot or a crew member of any aircraft; or the person is riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates; except as prescribed by a Doctor, use of: (1) PCP (also known as “Angel Dust”); (2) LSD or other hallucinogens; (3) cocaine, heroin or other narcotics; (4) amphetamines or other stimulants; (5) barbiturates or other sedatives or tranquilizers; or (6) any combination of two or more of these substances; any poison or gas voluntarily taken, administered, absorbed, or inhaled (except in the course of employment) (This provision may vary by state. Refer to the plan booklet for details).

FOR RESIDENTS OF ALL STATES EXCEPT FLORIDA, NEW JERSEY, NEW YORK, PENNSYLVANIA, VIRGINIA, VERMONT AND WASHINGTON; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

FLORIDA RESIDENTS – Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident coverage.

PENNSYLVANIA RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT AND WASHINGTON RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

“Unintentional injuries are the fifth leading cause of death overall and first among persons in age groups from 1 to 44.” -National Safety Council, Injury Facts, 2009 Edition. *Unfortunately, most families will be financially unprepared for this unexpected loss.

We are pleased to provide you with the opportunity to purchase Voluntary Accident Insurance. This plan is flexible enough to fit anyone’s budget because you choose the exact Amount of Insurance you need and can afford. And it’s easy to pay for as your premiums are automatically collected through convenient payroll deductions. What’s more, you can’t be turned down for this protection and you don’t have to take a physical exam. We urge you to consider including this Plan in your insurance portfolio.

How the Plan Works

Eligible participants will be protected 24 hours a day, 365 days a year, for covered accidents occurring anywhere in the world, on or off the job, at home or while traveling (subject to the Exclusions and Limitations of the contract). These program benefits are paid in a lump sum.

ELIGIBILITY

All active full-time employees working at least the minimum hours required by the Contract Holder, their Spouse or Registered Domestic Partner* as defined in the Group Contract, and their children from live birth to 26 years of age. Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, Registered Domestic Partner’s children and foster children. A child placed with you for adoption prior to legal adoption is considered your Qualified Dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you. If both parents are eligible, the children may be covered as dependent(s) by only one parent. A person insured as an employee may not be covered as a spouse or dependent of another employee.

* Your Registered Domestic Partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a Registered Domestic Partnership.

AMOUNT OF INSURANCE

Employee Coverage - For Your Own Protection - You may cover yourself under the Employee Only Plan or Family Plan, but not both.

BENEFIT CLASSES	AMOUNT OF INSURANCE
Option I - All Employees:	\$1,000
Option II - All Employees:	ANY MULTIPLE OF \$10,000, PLUS \$1,000
	But if you elect a multiple in excess of \$250,000, the maximum amount is the lesser of (1) and (2); (1) 10 times your annual earnings, PLUS \$1,000. (2) \$501,000.00

* Annual Earnings is defined as the gross amount of money paid to you by the employer in cash for performing the duties required of your job. Bonuses, overtime pay, earnings for more than 40 hours per week, and all other benefits are not included.

Spouse and Dependent Children Coverage – Family Protection

If elected, the Family Plan will automatically insure: (1) You for the Amount of Insurance checked on your Enrollment Form; (2) Your spouse - **60%** of your Amount of Insurance if you have no eligible children or **50%** if you do have eligible children; (3) Your Children - **10%*** of your Amount of Insurance* for each child if you are married or **25%*** of your Amount of Insurance for each eligible child if you are a single parent.

*The Maximum Amount of Insurance for each child cannot exceed \$50,000.

REDUCTION IN AMOUNT OF INSURANCE

The reductions are as follows: At age 70, your Amount of Insurance will reduce to 50% of your pre-age 70 amount. Dependent Benefits (as stated in the Family Plan) will reduce proportionately independent of age when you reach 70.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

100% of the Amount of Insurance	75% of the Full Amount of Insurance	50% of the Full Amount of Insurance	25% of the Full Amount of Insurance
Loss of life or Loss of two or more members or Loss of speech and hearing of both ears Quadriplegia (total paralysis of both upper and lower limbs.)	Paraplegia (total paralysis of both lower limbs.)	Loss of one member or Loss of speech or hearing of both ears Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	Loss of hearing of one ear or Loss of thumb and index finger of the same hand

“Member” means hand, foot or eye.

“Loss must occur within 365 days of the date of the covered accident.”

DEPENDENT CHILD LOSS BENEFIT

If a child suffers paralysis or dismemberment, the Plan provides an additional Amount of Insurance equal to **100%** of the amount payable for the one largest amount to which the child is entitled.

LOSS DUE TO EXPOSURE AND DISAPPEARANCE

Loss resulting from exposure to the elements shall be covered to the extent of the benefits afforded an Insured. If the body of an Insured has not been found within one year of the disappearance, stranding, sinking or wrecking of any vehicle in which an Insured was an occupant. It shall be presumed subject to all other provisions and conditions of the policy that an Insured has suffered loss of life covered under this policy.

MONTHLY COMA BENEFIT

If a covered insured is injured in a covered accident which results in a coma for at least 31 consecutive days, the Plan will begin payment of a Monthly Coma Benefit. Payment of this benefit will continue each month as long as the covered person remains in a coma, up to a maximum of 100 months. This benefit will be paid at a rate of **1%** of the Amount of Insurance less any benefits paid as a result of the same covered accident. "Coma" means being in a profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's Doctor.

CONTINUED ACCIDENT INSURANCE AFTER YOUR DEATH

If you elect the Family Plan coverage and die in a covered accident, your family's coverage will be continued, at no cost to your family, for a period up to 12 months from the date of your death, provided your spouse and/or dependent children remain eligible under the Plan. At the end of the 12-month period, coverage ends.

CHILD CARE EXPENSE BENEFIT

If you elect the Family Plan coverage and you or your insured spouse die in a covered accident, the Plan will provide child care assistance to each eligible dependent child under the age of 13 who is enrolled in a licensed child care center, or who enrolls in a licensed child care center within **90** days from the date of the covered accident. This important benefit pays **5%** of the applicable Amount of Insurance up to **\$5,000** yearly for up to 4 consecutive years, but not beyond the date the child reaches age **13**. If you have no eligible children who qualify, the Plan will pay **\$1,000** to your beneficiary.

TUITION REIMBURSEMENT BENEFIT FOR SPOUSE

If you elect the Family Plan coverage and you die in a covered accident, the Plan will provide a Tuition Reimbursement Benefit to your eligible spouse. A spouse must enroll within 365 days of your death in a training program for the purpose of obtaining an independent source of income. This Tuition Reimbursement Benefit is a lump-sum payment of **5%** of your Amount of Insurance or **\$5,000** whichever is less.

TUITION REIMBURSEMENT BENEFIT FOR CHILDREN

If you elect the Family Plan coverage and you or your insured spouse die in a covered accident, the Plan will provide a Tuition Reimbursement Benefit to each eligible dependent child who is a full-time student at a college, university, vocational school, or trade school over the **12th** grade level at the time of (or enrolls within **365** days of) your death. This Tuition Reimbursement Benefit is an annual payment of **5%** of the applicable Amount of Insurance or **\$5,000**, whichever is less. Payments will be made each year for up to four consecutive years for each child who qualifies, but not beyond the date the child reaches age **25**. Benefit payments will cease when the child ceases to be a full-time student. If there are no dependent children who qualify for this benefit, a single lump-sum of **\$1,000** will be paid to your beneficiary.

SEAT BELT/AIR BAG BENEFIT

If the Insured dies in automobile accident and is wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer, the plan will pay an additional **10%** of the Principal Sum to a maximum of **\$25,000**. In addition, if the Insured dies in an automobile which is equipped with an air bag for the location in the car in which the Insured was seated and the Insured was wearing his seat belt, an additional benefit of **10%** of the Principal Sum may be paid. Both the Seat Belt and Air Bag must meet published federal safety standards, which had been installed by the automobile manufacturer, and which has not been altered after such installation. Actual use of the Seat Belt and Air Bag at the time of the injury must be verified in an official report of the accident, or be certified in writing by the investigating official.

CRITICALLY BURNED BENEFIT

If you are accidentally critically burned over **25%** of your body (above second degree burns) and/or permanently disfigured to the point of requiring reconstructive or cosmetic surgery, a Critically Burned Benefit shall be payable. This benefit will be **25%** of your Principal Sum or **\$25,000** whichever is less.

PORTABILITY BENEFIT

Coverage will end on termination of employment as specified in the Contract. You may continue your group insurance through a portability provision if you meet all of the following criteria. Your Optional Accidental Death and Dismemberment Coverage ends for any reason other than your failure to pay, when due, any contribution required for it; or the end of your employment on account of your retirement; or the end of the Coverage for all Employees when such Coverage is replaced by group accidental death and dismemberment insurance from any carrier for which you are or become eligible within the next **31** days. You must also meet the Active Work Requirement on the day your insurance ends, you are less than age 80 and your Amount of Insurance is at least **\$20,000** under the Optional Accidental Death and Dismemberment Coverage on the day your insurance ends.

BENEFICIARY

You may name any beneficiary or beneficiaries you wish. If you purchase coverage for your family under the Family Plan, you are automatically your dependents' beneficiary for loss of life.

TERMINATION OF COVERAGE

Insurance will continue as long as the Insureds remain eligible through the Contract Holder, continue to pay the premiums, and the Master Contract is not terminated. Coverage for your dependents will terminate when your coverage terminates, or when they no longer qualify under the plan.

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective on the first day of the month following the date your completed enrollment form is received by the Contract Holder.

ENROLLMENT PROCEDURES

You may enroll by completing the enrollment form below and returning it to your Personnel Office. Please retain a copy for your records. This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.



Voluntary Accidental Death and Dismemberment Insurance

AG-43240-CA

AMOUNT OF INSURANCE	EMPLOYEE ONLY	FAMILY COVERAGE
Select a benefit in increments of \$10,000 subject to a maximum of \$500,000 , plus \$1,000 . For amounts greater than \$250,000 , your benefit may not exceed ten times (10x) your Annual Earnings. \$ _____	<input type="checkbox"/> Yes, Please provide coverage for me only.	<input type="checkbox"/> Yes, Please provide coverage for me and my family members.
<input type="checkbox"/> I have been given the opportunity to enroll for this insurance but I do not desire to participate, but I understand that I am insured for \$1,000 .	<input type="checkbox"/> Please deduct from my salary the premium for the insurance for which I have enrolled.	

Employee Name: _____ Employee SS# : _____
 Last First MI

Annual Earnings : _____

Spouse Name: _____ Spouse SS# : _____
 Last First MI

Primary
 Beneficiary: _____ Relationship: _____ Percentage: _____

Address: _____

Contingent
 Beneficiary: _____ Relationship: _____ Percentage: _____

Address: _____

TENTHLY COSTS			MONTHLY COSTS		
Amount of Insurance	Employee Only	Family Plan	Amount of Insurance	Employee Only	Family Plan
\$ 10,000	\$.65	\$.97	\$ 10,000	\$.54	\$.81
20,000	1.30	1.94	20,000	1.08	1.62
30,000	1.94	2.92	30,000	1.62	2.43
40,000	2.59	3.89	40,000	2.16	3.24
50,000	3.24	4.86	50,000	2.70	4.05
60,000	3.89	5.83	60,000	3.24	4.86
70,000	4.54	6.80	70,000	3.78	5.67
80,000	5.18	7.78	80,000	4.32	6.48
90,000	5.83	8.75	90,000	4.86	7.29
100,000	6.48	9.72	100,000	5.40	8.10
125,000	8.10	12.15	125,000	6.75	10.13
150,000	9.72	14.58	150,000	8.10	12.15
200,000	12.96	19.44	200,000	10.80	16.20
250,000	16.20	24.30	250,000	13.50	20.25
300,000	19.44	29.16	300,000	16.20	24.30
400,000	25.92	38.88	400,000	21.60	32.40
500,000	32.40	48.60	500,000	27.00	40.50

Employee's Signature: _____ Date (Month, Day, Year) _____

(For Office Use Only) Effective Date: _____