TERMS & CONDITIONS

OCCUPATIONAL ACCIDENT & CONTINGENT LIABILITY BENEFITS-PACKAGE PROGRAM

Carefully read all of these Terms & Conditions. If you agree with these Terms & Conditions, indicate your assent below.

THE BENEFITS ARE DESCRIBED IN THESE TERMS & CONDITIONS

The benefits of the Group Coverage of this Truck Owners Association ("TOA") Program are described in these Terms & Conditions. When you apply to enroll in this Program, you are applying for Occupational Accident Benefits, plus TOA's Discount Benefit and Prescription Drug Benefit. If you chose the optional Contingent Liability Benefits option, you are applying for those benefits as well. You also may choose the ID Protection option. These are the Terms & Conditions when You are insured under the Group Coverage of this TOA Program.

WHY IT IS IMPORTANT TO READ ALL OF THESE TERMS & CONDITIONS

Read the entire Terms & Conditions carefully because You are entitled to benefits only as described in these Terms & Conditions, so it is very important to read them.

TOA BENEFITS-PACKAGE PROGRAMS IN GENERAL

A. To Whom The TOA Benefits-Package Programs Are Available. TOA's Benefits-Package Programs and the benefits they provide are available and applicable only to active TOA Members and/or their Sponsors. Active TOA membership is required to be eligible for any benefit under TOA Programs.

B. Contract Between You And TOA.

When you submit a Quote/Application as a Sponsor requesting to enroll your specified Independent Contractor drivers as TOA members and as Occupational Accident coverage Subscribers, the Quote/Application is your offer to enter into a contract with TOA to enroll those drivers as TOA members and as Occupational Accident coverage Subscribers. If you also have requested the optional Contingent Liability Benefits option, you are further offering to enter into a contract with TOA to enroll you as a Named Insured eligible for Contingent Liability coverage. A term of the offer is that TOA can accept the offer only by issuing a TOA Certificate. As your part of the bargain, you promise to be bound by these Terms & Conditions, the terms in the Quote/Application, the terms of the Group Policy and the terms in

the Certificate, if in exchange TOA issues a Certificate and enrolls your drivers for Occupational Accident Benefits, and if you requested the Contingent Liability option, enrolls you for Contingent Liability Benefits. As TOA's part of the bargain, in exchange for your promise to be bound and your down payment, TOA promises that if you and your drivers are eligible, TOA will enroll you and your drivers, issue a Certificate and provide the benefits of the TOA Benefits-Package Program in accordance with these Terms & Conditions, the terms in the Quote/Application, the terms in the Group Policy and the terms in the Certificate.

When TOA manifests its assent and accepts your offer by issuing the Certificate, at that moment the Application, the Terms & Conditions, the Group Policy and the Certificate become the binding Contract between you and TOA ("the Contract"). TOA's issuance of the Certificate and enrolment of your drivers for Occupational Accident Benefits, and if you requested the Contingent Liability option, enrolment of you for Contingent Liability Benefits, is TOA's consideration for your promise to be bound. Your down payment and promise to be bound is consideration for TOA's promise that if you and your drivers are eligible, TOA will enroll you and your drivers, issue a Certificate and provide the benefits of the TOA Benefits-Package Program. No Contract is created until TOA accepts your offer by issuing a Certificate.

TOA's decision whether to accept your offer will be based on whether the drivers are acceptable drivers with acceptable loss histories. Motor vehicle reports (MVRs) showing each driver's driving and license history will be required to bind any benefit under the Programs. TOA may ask you to withdraw this offer and submit a new Application with different pricing based on new information received on the autos and/or drivers quoted.

C. You May Cancel The Contract If You Later Decide You No Longer Like The Terms & Conditions. If you later decide that you no longer like the Terms & Conditions, or that you want to cancel coverage for any reason or even no reason, you can cancel the Contract at any time. However, because premiums are fully earned on the 1st day of each month, if you do not cancel by the end of the last day of the month, then on the 1st day of the new month the new month's premium will be fully earned on due.

D. Cancellation Of The Contract By TOA Or Insurer.

TOA or the Insurer may cancel the Occupational Accident and/or Contingent Liability coverage benefits for any of the following reasons:

- Nonpayment of premium;
- The coverage was obtained through a material misrepresentation;
- You or your Subscriber violated or failed to comply with any of these Terms and Conditions or those of the Policy;
- The risk originally accepted has measurably increased;
- Statutory reasons.

If coverage was obtained through a material misrepresentation, the Contract and coverage will be considered cancelled on the inception date.

E. Effect Of Cancellation Of The Contract On Premiums. Upon cancellation by either you or TOA or the Insurer, the premiums paid are fully earned and no return premium will be due or payable. lf you owe premiums for a period prior to the cancellation date, such premiums will be payable at the time of cancellation.

F. Adding Subscribers; Deposits; When Premiums Are Due; When Premiums Become Fully-Earned; Removing Subscribers; Cancellation For Non-Payment Of Premiums.

A deposit of one month's premium will be held for each Subscriber. If you add a Subscriber after the 20th day of the month, no premium is due for that Subscriber for that month.

Premiums are payable monthly. For the upcoming month, a premium payment in cleared funds must be received by TOA or its designee before the 1st day of the upcoming month. TOA or its designee will take payment of the premium up to five (5) days before the 1st day of the upcoming month.

Even if you fail to pay the premium in cleared funds before the 1st day of the upcoming month, if you fail to notify TOA or its designee before the 1st day of the new month that you are removing the Subscriber, then coverage for that Subscriber rolls over on a short-term basis into the new month.

Premiums are fully earned on the 1st day of each month. Therefore, if a Subscriber is covered on the 1st day of the new month because the premium was paid, or because you failed to notify TOA or its designee that you are removing the Subscriber, the new month's premium is fully earned on the 1st day of the new month for that Subscriber.

Once a premium is fully earned, if still unpaid then the entire month's premium is owed and must be paid to TOA, and if already paid then no refund or return premium will be due or payable from TOA, with one exception. The exception is that you may remove the Subscriber up to and including the 10th day of the month and not owe any premium for that month if:

1. you notify TOA or its designee in writing by that 10th day of the month that you have removed the Subscriber and are requesting that TOA cancel the Subscriber's coverage retroactively as of the end of the last day of the preceding month, so that no coverage existed by the 1st of the month;
2. the Subscriber was not involved in an occupational accident on or after the 1st of the month; and
3. you provide written proof to TOA or its designee that you notified your Subscriber in writing that you terminated their coverage on the last day of the preceding month.

If you already paid the premium, the premium will be refunded and the deposit will also be returned

If the premium for a Subscriber was NOT paid in cleared funds before the the 1st day of the upcoming month, and neither you nor the Subscriber canceled coverage before the 1st day of the new month, then TOA or its designee will notify you and/or the Subscriber that coverage will no longer be in effect as of

the 10th calendar day after the notification date, which 10th day will be the cancellation effective date. At 12:01 a.m. of that date, coverage will no longer be in effect. The notice will further advise you of the aforementioned procedure for removing the Subscriber up to and including the 10th day of the month without owing any premium for that month.

If you forgo or are ineligible for the aforementioned procedure, TOA will apply your deposit toward the fully earned premium and coverage will continue until the cancellation effective date.

If the premium payment in cleared funds is received before the cancellation effective date, that payment will rescind the cancellation notice and TOA will notify you that your cancellation notice has been rescinded. In that event, TOA will reverse the application of your deposit toward the fully earned premium and convert it back to a deposit.

If your cancellation goes into effect, TOA will notify you that your coverage was cancelled as of the cancellation effective date.

Once coverage is cancelled, you have up to 30 calendar days from the cancellation effective date to request reinstatement of coverage, pay all premiums, pay a reinstatement fee, and submit a signed TOA-approved "No Loss Letter." If TOA approves your request, the coverage will be reinstated retroactively as though the coverage had not lapsed. However, these payments and all future payments must be made in legal tender or cleared funds directly to TOA. Payment to an agent is not acceptable as payment to TOA once a cancellation occurs.

If more than 30 calendar days elapse from the cancellation effective date, a completely new Application/offer must be submitted. If TOA approves the reinstatement request, coverage will be re-written. Once you pay all premiums, pay a reinstatement fee, and pay any other fees or monies due, TOA will issue a new Certificate of Insurance with a new effective date. These and all future payments must be made in legal tender or cleared funds.

If less than 60 calendar days elapsed from the cancellation effective date, TOA may at its sole discretion re-write coverage using the most current information that TOA has on file as to drivers and risks. If 60 or more days elapsed, new information must be submitted.

Cancellation of coverage does not waive your responsibility to immediately pay all premiums, fees, dues or other debts that you owe. Debts not paid in a timely manner will be transferred to a collection agency.

G. Premiums May Rise Due To Inaccurate Or Incomplete Information. TOA will determine your premium amount once you have completed your Quote/Application for the specified TOA Benefits-Package Program and benefits. In order to provide you with an accurate premium, TOA relies on you to provide accurate and complete information. TOA will, to the extent allowed by law, verify the information you have provided through third-party providers. If TOA learns the information was inaccurate or incomplete, the premium amount may increase. You or TOA may also cancel the Contract.

H. The Insurer May Increase Premium Rates For Occupational Accident Coverage. The Insurer will not increase premium rates for Occupational Accident coverage during the initial 12 months of coverage and not more than once in any 6-month period following the initial 12-month period, except for increases due to a change in age or geographic location of a covered Subscriber or an increase in the Policy benefit level. TOA will notify the Sponsor or Subscriber of any change at least 30 days before the premium due date on which the new rates are to be effective and at least 45 days before an increase of 20% or more is effective.

I. The Insurer May Increase Premium Rates For Contingent Liability Coverage. The Insurer has the right to change the rates at which future premiums will be calculated on the 1st day of any month. TOA will notify you of any change at least 30 days before the premium due date on which the new rates are to be effective. The Insurer may only make one rate change during the Coverage Period shown in the Certificate.

J. Waiver Of Premium When Total Disability Applies. The Insurer will waive premium for a Subscriber on the 1st of the month following the date the Insurer receives due written proof of the Subscriber's Total Disability. This provision is subject to all of the provisions of these Terms & Conditions, except as to the payment of premium. If a Subscriber's Total Disability ends and the Subscriber is still eligible for insurance under these Terms & Conditions, the Certificate and the Policy, coverage will continue provided that premium is paid beginning with the 1st of the month following the Subscriber's return to active work.

K. Changes to Terms & Conditions and Policy. These Terms & Conditions, and those of the Policy, may be changed at any time by the *Insurer* or TOA. It is not necessary to have the consent of the *Sponsors* or *Subscribers*/beneficiaries to make such changes. Such changes are made by an amendment, rider or endorsement, signed by an officer of the *Insurer* or TOA. No agent may make such change in any way, shape or form. The *Insurer* and TOA are not bound by any promise or statement made by any individual or agent which is contrary to the TOA Certificate, or to these Terms & Conditions or those of the Policy, and which is not approved in writing by the *Insurer* and/or TOA. Any unwritten agreements, statements, representations and/or promises are invalid, null and void.

If a change requires a premium adjustment, the premium will be adjusted as of the effective date of change. The change becomes effective as of the amendment's, rider's or endorsement's effective date.

You have the right to reject any change. If you want to reject a change, you must notify TOA in writing within 30 calendar days of being notified of the change. If you reject a change, TOA will cancel your Contract. You will still be responsible for any payments that are owed.

You also have the right to cancel the Contract. If you cancel the Contract, you will still be responsible for any payments that are owed.

L. If TOA Switches Insurers. The Occupational Accident and Contingent Liability Benefits-Package Program is based on an underlying Group Policy issued by an Insurer. If TOA switches to a different

Insurer, TOA will notify you and give you the option to cancel the Contract between you and TOA.

ADDITIONAL BENEFITS

Upon enrollment in this Program and TOA membership, your Independent Contractor drivers receive the following benefits of TOA membership:

a. Accidental Death & Dismemberment ("ADD") Benefit. Enrolled drivers receive ADD coverage up to $50,000. For a low additional cost, you have the option of providing ADD coverages up to $200,000 to your drivers. You and your drivers are bound by the Terms & Conditions of the underlying Death & Dismemberment Insurance Policy, which is available upon request.

b. Discount Benefit. Enrolled drivers receive discounts on lodging and vehicle rentals.

c. Prescription Drug Benefit. Enrolled drivers receive discounts on prescription drugs.

d. Identity Theft Protection Benefit. For a low additional cost, you have the option of providing identity theft protection to your enrolled drivers.

OCCUPATIONAL *ACCIDENT* BENEFITS ONLY

(Italicized words in the Occupational *Accident* Benefits part of these Terms & Conditions means that those terms are defined in **Section 7 – Definitions**.)

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IMPORTANT NOTICE

All States except Texas: IMPORTANT NOTICE: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.

Texas: IMPORTANT NOTICE: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BV 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 THAT MUST BE FILED AND POSTED.

SCHEDULE

This Schedule is a very brief summary of the Occupational Accident Benefits. Please read the entire Terms & Conditions for a more complete description of the benefits outlined in this Schedule.

TOA and the *Insurer* certify that a Group Policy providing *Occupational Accident* coverage has been issued to TOA, bearing the Policy number shown in **Item # 2** of this **Schedule**.

Item 1. Master *Policyholder*: Truck Owners Association

Item 2. Policy Number: R170017, underwritten by Certain Underwriting Members of Lloyd's of London.

Item 3: Named Insured Number:

Item 4: Named Insured:

Item 5: Named Policyholder Effective Date: 1st February 2017 12:01 AM, Standard Time at the the address of the Policyholder.

Named Policyholder Expiration Date: 1st February 2018 12:01 AM Standard Time at the address of the Policyholder.

Item 6. Covered *Subscriber*: As named and reported on the monthly census by the *Policyholder* and stated in the *Certificate.*

Item 7. *Subscribers* Enrollment Date: As on file and stated in the *Certificate*.

Item 8. Eligible Classes: As shown below and defined in the Covered Activity Rider.

Item 9. Covered Activities - Refer to Covered Activity Rider – Trucking Operation.

Item 10. Coverage Basis: Insurance for *Subscribers* is limited to Occupational-Related Injuries only.

Item 11. Amounts of Insurance:

Occupational *Accident* Benefits

***Accidental* Death Benefit**

Principal Sum:	USD 25,000
Commencement Period:	365 days

(Commencement Period means the period between the date of the covered *Accident* that caused the *Injury* and the date on which the covered loss must occur for benefits to be payable. Thus, the *Injury* to the *Subscriber* must result in death within 365 days of the date of the covered *Accident* for the Accidental Death Benefit to be payable.)

Survivors Benefits

Principal Sum:	USD 75,000
Monthly Benefit:	1% per month

***Accidental* Dismemberment Benefit**

Principal Sum:	USD 100,000
Commencement Period:	365 days

Paralysis Benefit

Principal Sum:	USD 100,000
Commencement Period:	365 days

Temporary Total Disability Benefit

Commencement Period:	90 days
Waiting Period:	7 days
Benefit percentage:	75% of *Average Weekly Compensation*
Minimum Weekly Benefit:	USD 125
Maximum Weekly Benefit:	USD 250
Maximum Benefit Period:	52 weeks

(The Disability must begin within 90 days from the date of the covered *Accident*.)

Continuing Total Disablement Benefit

Waiting Period:	52 weeks
Benefit percentage:	75% of *Average Weekly Compensation*
Minimum Weekly Benefit:	USD 50
Maximum Weekly Benefit:	USD 250
Maximum Benefit:	USD 100,000
Maximum Benefit Period:	to age 65

***Accident* Medical Expense Benefit**

Commencement Period:	90 days
Deductible:	Nil
Maximum Benefit Period:	104 weeks
Dental Maximum:	USD 2,500 per covered *Accident*
Maximum Benefit per covered *Accident*:	USD 50,000
Lifetime Maximum Benefit:	USD 50,000

(For this benefit to be payable, the First Expense for *Injury* caused by a covered *Accident* must be *Incurred* and reported within 90 days from the date of the covered *Accident*, and any further Expenses for *Injury* caused by the covered *Accident* must be *Incurred* within 104 weeks from the date of the covered accident.)

Limits on *Accident* Medical Expense Benefits

Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy	USD 1,000 per *Injury*
Ambulance	One round trip to & from the *Hospital* but not more than than USD 1,000 for any one covered *Accident*
Air Ambulance	One round trip to & from the *Hospital* but not more than than USD 7,000 for any one covered *Accident*
Mental and Nervous – *Outpatient*	USD 25 per visit Maximum 20 visits for any one covered *Accident*
Mental and Nervous – *Inpatient*	Maximum 20 days Maximum USD 1,000 for any one covered *Accident*

Limits of Liability

Combined Single Limit:	USD 100,000 per Insured
Occurrence Limit:	USD 200,000 per Occurrence

*The *Accidental* Dismemberment Benefit and the Paralysis Benefit will be paid as a Monthly Benefit at 1% of the applicable Principal Sum. The payment of this Monthly Benefit will cease upon the earliest of the following: (1) the date the total of the applicable Principal Sum has been paid; or (2) the date the *Subscriber* dies. The most the *Insurer* will pay for these benefits, as well as the *Accidental* Death Benefit, in total is the *Subscriber's* Principal Sum, if the *Subscriber* can recover benefits under more than one benefits as a result of the same covered *accident*.

At age 65, the Subscriber's Principal Sum will be based on the following schedule:

Age at Date of Benefit Payment	% of Principal Sum
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

**lf the *Subscriber* sustains a Covered *Injury* at or after age sixty five (65), the Maximum Benefit Period will be one (1) Year.

***lf the *Subscriber* sustains a Covered *Injury* after the *Subscriber's* normal Social Security retirement age, as determined by federal law, the *Subscriber* cannot qualify for Continuous Total Disablement.

Schedule of *Accidental* Death & Dismemberment Benefit for Loss of:	**Principal Sum**
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
Speech	50%
The Sight of One Eye	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

Functional Loss of Use: lf *Injury* to the *Subscriber* results within 365 days of the date of the the covered *Accident* that caused the *Injury* in any one of the losses specified below, the *Insurer* will pay the percentage of the Principal Sum shown below for that Loss:

Functional Loss of Use:	**Principal Sum**
Use of 4 Limbs	100%
Use of 3 Limbs	75%
Use of 2 Limbs	50%
Use of 1 Limb	25%

Item 12. Additional Conditions and Limitations:

1. Premium Payment Mode:	Monthly
2. Premium Calculation Mode:	15th of the Month
3. Age Limit (see Uniform Provisions for more details)	Age 65

Item 13. **In the event of a claim please notify the following:** As per *Certificate*

Item 14. **Forms, endorsements and riders attached to and made a part of this Coverage at issuance:**

Covered Activity Endorsement (Trucking Operation)

SECTION 1 – WHEN COVERAGE STARTS

When a *Sponsor's* Coverage Commences

A *Sponsor's* coverage will begin on the *Sponsor's Effective Date*.

Eligibility and When a *Subscriber's* Coverage Commences

The Eligibility is identified by the Eligible Class descriptions as shown on the **Schedule** and defined in the Covered Activity Rider.

A *Subscriber's* coverage commences on the date stated in the *Certificate* issued by TOA, with one exception: If the *Subscriber* is away from work because the *Subscriber* is disabled, coverage will not start until the *Subscriber* is no longer disabled and returns to active work, but only if he/she returns to active work before the expiration date stated in the *Certificate*.

SECTION 2 – WHEN COVERAGE STOPS

When a *Sponsor's* Coverage Stops

A *Sponsor's* coverage under the *group policy* shall terminate when:

- The *Insurer* gives advance written notice of termination of the *group policy* for any reason; or
- TOA requests in writing to the *Insurer* that the *group policy* be terminated; or
- The *Sponsor* fails to pay the required premium or portion thereof when due (subject to any Grace Period); or
- TOA receives a written request from the *Sponsor* to terminate the Sponsor's participation in the *group policy*.

When a *Subscriber's* Coverage Stops

A *Subscriber* may request that the *Subscriber's* coverage be terminated by completing the necessary written notice and forwarding it to the *Sponsor*. The effective date of termination will be the earliest of the following:

- the date the *Sponsor* receives a written request for termination from the *Subscriber*; or
- when the *Subscriber* is no longer in an Eligible Class; or
- when the *Subscriber* stops making payments for the coverage (subject to any Grace Period); or
- when the *group policy* terminates; or
- when the *Sponsor* stops participating in this insurance; or
- when any applicable age limit is attained.

SECTION 3 – BENEFIT PROVISION

Benefits hereunder are only payable for loss sustained by a covered accident. NO BENEFITS ARE PAYABLE IN CONJUNCTION WITH AN ILLNESS OR SICKNESS, AS DEFINED HEREIN.

Coverage A, B, C, or D are provided as indicated on the Schedule.

Coverage A. – *ACCIDENTAL* DEATH BENEFIT

If a *Subscriber* suffers death within 365 days after a covered *Accident*, *Accidental* Death Benefits will be paid to the *Subscriber's* eligible beneficiary(ies). The benefit payable will be in accordance with the terms, conditions, limitations and exclusions of these Terms & Conditions and any Maximum Benefit as shown in the **Schedule**. The death must result directly and solely from such covered *Accident* and be independent of illness, disease or bodily infirmity.

Installment Payment

The initial Death Benefit is shown in the **Schedule**. The remaining balance will be payable as a Survivor's Benefit in monthly installments of 1% per month for a period of 100 months after the initial payment has been made, or until the satisfaction of the Survivor's Benefit, whichever occurs first. The *Subscriber's* beneficiary may not elect payment in one sum.

If a *Subscriber* dies within 365 days after a covered *Accident* and before attaining the Age Limit and is survived by an eligible beneficiary, the Survivor's Benefit will be payable. This benefit will be paid in accordance with the terms, conditions, limitations and exclusions of these Terms & Conditions, and subject to the following:

- If a *Subscriber* is survived by a spouse, the spouse will receive a monthly benefit until he/she dies, remarries, enters into a common-law or civil partnership, or until the Maximum Benefit is paid, whichever occurs first;

- If the spouse is no longer eligible to receive this benefit, then any eligible Dependent Child(ren) will receive this benefit until no longer eligible, or until the Maximum Benefit has been paid, whichever occurs first. Benefits to any Dependent Child(ren) ceases upon the child's attainment of age 19, or age 23 if enrolled as a full-time student in an accredited secondary school, vocational school, college or university;
- If there are no eligible beneficiaries, no Survivor's Benefit will be paid.

Beneficiary

A person becomes a beneficiary only if a *Subscriber* has named them as a beneficiary on an approved beneficiary form. Beneficiary designations may be changed by filling out a Change of Beneficiary form. If no beneficiary is named, the applicable *Accidental* Death Benefit will be paid to the *Subscriber's* estate.

Coverage B. – *ACCIDENTAL* DISMEMBERMENT BENEFIT

The benefits payable will be in accordance with all of the terms, conditions, limitations and exclusions of these Terms & Conditions including the attached **Schedule**. The loss must result directly and solely from such covered *Accident* and be independent of disease or bodily *infirmity*.

The Principal Sums for Dismemberment and/or Functional Loss of Use are shown in the **Schedule.**

The term "Dismemberment" means a complete separation of a limb from the body. "Hearing or Speech Loss" means the total and irrecoverable loss of hearing or speech. "Loss of Hand" means removal at or above the wrist joint. "Loss of Foot" means removal at or above the ankle joint. "Loss of an Eye" means the total and irrecoverable loss of sight. "Loss of Thumb and Index Finger of the Same Hand" means the actual, permanent and complete severance through or above the metacarpophalangeal joints. "Functional Loss of Use" means complete paralysis of the entire limb which cannot be recovered.

If more than one Dismemberment, Loss of Life or Functional Loss of Use results from any one covered *Accident*, the benefit payable is the total percentage of the Principal Sums indicated in the **Schedule**. However, the most the *Insurer* will pay for all loss resulting from one covered *Accident* is 100% of the Principal Sum.

Coverage C. – *ACCIDENTAL* DISABILITY BENEFIT

The *Insurer* will pay an *Accidental* Disability Benefit for each week of a *Subscriber's* disability as stated in the **Schedule**. Payment will not be made during the *Waiting Period* indicated on the **Schedule**. Once the applicable *Waiting Period* is satisfied, benefits will be payable as shown in the **Schedule**.

In order to be considered under this Benefit provision, disability must (1) result from a covered *Accidental Injury*, (2) begin within the Disability Reporting Period shown in the **Schedule**, (3) require the ongoing care of a legally qualified *Physician*, and (4) prevent a *Subscriber* from engaging in work for compensation, wage or profit.

The definition of Total Disability is further limited in scope as follows:

Temporary Total Disability, a benefit, up to the Maximum Weekly Benefit shown in the **Schedule**, will be payable for a *Subscriber's* inability to perform all of the substantial and material duties of the *Subscriber's* regular occupation as defined in the *Subscriber's Covered Contract* for up to the Maximum Payment Period shown in the **Schedule**; or

Permanent Total Disability, if the *Subscriber* is still disabled after the Maximum Payment Period for Temporary Total Disability, a benefit will be payable, up to the Maximum Payment Period for Permanent Total Disability as shown in the **Schedule**, if the *Subscriber*:

- Cannot engage in any work for pay or profit, and is unable to perform all of the substantial and material duties of ANY occupation or employment which the *Subscriber* might qualify for by reason of education, training or experience; and

- Is granted a Total Disability Award status and starts receiving disability payments by the Social Security Administration for such Total Disability. If the *Subscriber* is ruled ineligible based on the status or the *Subscriber* is ineligible for Social Security Administration disability payments for any reason, the *Subscriber* will also be deemed ineligible for payments under this Permanent Total Disability benefit.

For Temporary Total Disability, the *Accidental* Disability Benefit will be payable for the duration of the Disability after satisfying any applicable *Waiting Period*. For any Total Disability of less than one Week, one-seventh of the Weekly Benefit will be payable per full day of Disability. For Permanent Total Disability, the monthly benefit will be equal to 4.3 times the Weekly benefit.

Separate periods of Disability resulting from the same or related causes will be considered one period of Disability unless separated by the *Subscriber's* return to active work or until the *Subscriber* can perform the daily functions of a person of like age in good health for at least six (6) consecutive months.

Separate periods of Disability resulting from unrelated causes will be considered one period of Disability unless separated by the *Subscriber's* return to active work or until the *Subscriber* can perform the daily functions of a person of like age in good health for at least one full day.

The Maximum Weekly Benefit payable will be a percentage of the *Subscriber's Average Weekly Compensation*. At the *Insurer's* discretion, benefits may be paid on a monthly or bi-monthly basis, instead of weekly. From time to time, the *Subscriber's* status will be reviewed and may require an accounting of earnings and/or proof of continued disability. The *Subscriber's* failure to furnish any such required information within 30 days of written notice may result in termination of coverage and/or benefits.

Reduction in Disability Income Benefits

The amount of Total Disability Income Benefits will be reduced by the amount of any Social Security benefits payable on account of such disability. This amount shall include any benefits payable to dependents. Cost-of-living increases in Social Security payments effective after the correct Social Security benefit has been determined will be used to reduce the *Insurer's* Disability Income Benefit.

Coverage D. – *ACCIDENT* MEDICAL EXPENSE BENEFITS

If the *Subscriber* suffers *Bodily Injury* in a covered *Accident* that requires medical attention, the *Insurer* will pay for *medically necessary* services or supplies as provided for herein. **There is no coverage under this benefit for the *Subscriber's sickness*, *illness* or ordinary disease of life (by whatever named called). However, if the *Subscriber* develops an *illness* or *disease* that is the result of and directly related to *Bodily Injury* which first occurred from a covered *Accident*, benefits will be payable as provided for herein. In any case, medical benefits payable are limited to expenses *Incurred* within the time frame specified under the Medical Incurral Period (as shown in the Schedule) or until any Maximum Benefit (as shown in the Schedule) has been paid, whichever occurs first.**

Subject to Utilization Management, payment for *medically necessary* and appropriate treatment will be made in accordance with these Terms & Conditions. These expense must be *Incurred* during the Medical Incurral Period shown in the **Schedule** up to the Maximum Benefit. This benefit is payable regardless of where the expenses are *Incurred*, whether in or out of the *hospital*, subject to Utilization Management as defined herein.

Charges: Payments for covered expenses are made based upon *usual, customary and reasonable* criteria that is procedure or service specific and calculated by geographic location. Benefits are payable only up to *usual, customary and reasonable* levels; amounts in excess of this amount will not be covered.

HOSPITAL EXPENSE

Subject to the *Accident* Medical provisions set forth herein, this benefit covers the *Subscriber's* stay in facilities including a general *hospital*, up to the stated limits shown in the **Schedule**. For stays in an Extended Care Facility or *Rehabilitation Facility*, this benefit covers the average room and board costs and miscellaneous services. The confinement must begin within 14 days of discharge from a *hospital confinement* of at least 3 days for the same or related conditions, provided a legally qualified *Physician* is supervising such care and certifies in writing that the patient continues to need skilled nursing care or supportive therapeutic services as part of a regimen of medical care.

SURGICAL PROCEDURES EXPENSE

Subject to the *Accident* Medical provisions set forth herein, this benefit covers the cost of surgical procedures undergone by the *Subscriber* as a result of a covered *Accidental Injury*, up to the amount customarily charged for the procedure in the geographical locality where it is performed.

DENTAL PROCEDURES AND ORAL SURGERY

Dental procedures are not covered, except for the prompt, necessary repair to a *sound natural tooth* which results from a covered *Accidental Injury*. Such *injuries* must occur while covered under the Certificate. Subject to the *Accident* Medical provisions set forth herein, certain oral surgical procedures are covered. Covered procedures are limited to the following:

- excision of unerupted, partly erupted or impacted teeth;
- repair of a fractured or dislocated jaw;
- osseous surgery;
- maxillofacial surgery.

ANESTHESIA EXPENSE

Subject to the *Accident* Medical provisions set forth herein, this benefit covers the costs of a legally qualified *Physician* (who is not the attending surgeon or assistant surgeon) who performed anesthetic procedures in connection with a surgical procedure for which benefits are payable due to a covered *Accident*. This benefit also covers the cost of the anesthetic itself. These charges are paid on a *usual, customary and reasonable* basis.

PHYSICIAN SERVICES EXPENSE

Subject to the *Accident* Medical provisions set forth herein, visits by a *Physician* for treatment of a covered *Accidental Injury* while the *Subscriber* is a registered bed patient in a *hospital*, will be paid on a *usual, customary and reasonable* basis. *Physician* care and treatment, including consultations, will be paid on a *usual, customary and reasonable* basis.

DIAGNOSTIC PROCEDURES EXPENSE

Subject to the *Accident* Medical provisions set forth herein, this benefit covers radiological or laboratory procedures recommended by a *Physician* or surgeon for diagnosis in connection with a covered *Accidental Injury*. Radiological and laboratory procedures must be rendered, where possible, at centers other than a *hospital*. Venipuncture is not covered. This benefit covers up to the *usual, customary and reasonable* charge.

PRESCRIPTION DRUG EXPENSE

Coverage for expenses *Incurred* by the *Subscriber* for prescription drugs shall be considered payable if necessary for the care and treatment of a covered *Accidental Injury* and only when prescribed by a *Physician* when:

- confined as an *inpatient* in a *hospital*; or
- administered as part of a *Physician's* office visit.

Incurred expenses are payable subject to the applicable Deductible, if any. No prescription drug expense benefits shall be paid for expenses related to:

- therapeutic devices or *appliances* (unless the Insurer authorizes coverage under Alternative Treatment Expense);
- any prescription which the *Subscriber* is entitled to receive without charge from any municipal, state or federal program;
- any prescription refilled in excess of or dispensed after one (1) year from the *Physician's* original order;
- immunization agents;
- *experimental* drugs.

HOME HEALTH CARE EXPENSE

Subject to the *Accident* Medical provisions set forth herein, this benefit covers certain services or supplies furnished to a *Subscriber* in their home in connection with a covered *Accidental Injury*. The services and supplies must be furnished under a program approved in writing by the attending *Physician*, as an alternative to continued *hospital* care, and must be provided by a certified *Home Health Care Agency* and pre-approved by the *Insurer*.

The services and supplies to which this benefit applies are:

- Part-time or intermittent nursing care by a Registered *Nurse*, or by a Licensed Practical *Nurse* under the supervision of a Registered *Nurse* if the services of a Registered *Nurse* are not available;
- Part-time or intermittent home health aide services which consist primarily of patient care of a medical therapeutic nature by other than a Registered or Licensed Practical *Nurse*;
- Physical therapy, occupational therapy, and speech therapy provided by the *Home Health Care Agency*;
- Medical supplies, drugs and medications prescribed by a *Physician*, and laboratory services by or on behalf of a *hospital* to the extent such items would have been covered under the *Hospital* Benefit if the *Subscriber* had remained in the *hospital*.

For determining the limit of benefits with respect to above services, each visit by a member of a home health care team shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

No payments will be made for:

- Services or supplies of a Home Health Care Agency furnished to anyone eligible for *Medicare*; or
- Services or supplies not included in a home health care plan; or
- Services of a person who ordinarily resides in the home, or is a member of the family; or
- Transportation services, and services and supplies provided to an individual primarily to assist him/her in the activities of daily living; or
- Any period during which the Subscriber is not under the continuing care of a *Physician*; or
- Expenses for services and supplies not related to medical care or treatment.

EMERGENCY ROOM EXPENSE

Subject to the *Accident* Medical provision set forth herein, emergency room costs for the treatment of an *Injury* arising from a covered *Accident* that requires Emergency Core as defined by these Terms & Conditions, are covered on *usual, customary and reasonable* basis.

COVERED MEDICAL EXPENSE

Subject to the *Accident* Medical provisions as set forth herein, the following are Eligible Expenses under the *Certificate*. All of the following medical expenses will be covered on a *usual, customary and reasonable* basis:

- *Hospital* charges for:
    - the actual Room and Board expenses *Incurred* subject to *usual, customary and reasonable* charges;
    - the actual expense *Incurred* for confinement in an Intensive Care Unit, Cardiac Care Unit or Burn Unit;
    - miscellaneous *hospital* services and supplies during *hospital* confinement.

- Charges *Incurred* for confinement in a *Rehabilitation Facility* or in a *Convalescent* or *Skilled nursing facility*. However, such expenses are limited as follows:
    - Charges will be considered only if confinement begins within 14 days after a *hospital* confinement of at least three (3) consecutive days; and
    - The Attending *Physician* certifies that confinement is *medically necessary*; and
    - Only charges *Incurred* in connection with care related to the covered *Accidental Injury* for which a *Subscriber* was confined will be eligible.

- Charges *Incurred* for Surgical procedures, as follows:

    - For *medically necessary* Surgical Procedures.

    - When two or more Surgical Procedures occur during the same operation, the Eligible Expense for all charges are as follows:
        - Charges for multiple surgical procedures performed during the same operative session which do not require separate incisions are handled as follows: the covered Eligible Expense for the greater procedure will be considered in full; the covered eligible expense for the next lesser procedure will be considered at 50%; and the covered eligible expense for any additional procedures will be considered at 25%.
        - When an incidental procedure is required because of a covered *Accident* and performed through the same incision, the Eligible Expense is the *usual, customary and reasonable* fee for the major surgical procedure only.

- When an assistant surgeon is required to render technical assistance at an operation, the Eligible Expense for such services shall be limited to 20% of the *usual, customary and reasonable* charge of the surgical procedure.

- *Usual, customary and reasonable* charges for the following oral surgery procedures:

  - Open or closed reduction of a fracture or dislocation of the jaw;
  - Osseous surgery;
  - Maxillofacial surgery;
  - *Accidental Injury* to a sound, natural tooth.

- *Usual, customary and reasonable* charges for reconstructive surgery, but only in the following situation: Treatment within six (6) months of a covered *Accidental Bodily Injury* sustained and treated while a *Subscriber*.

- *Usual, customary and reasonable* Charges, as follows:

  - for the services of a legally qualified *Physician* for medical care and/or surgical treatment including office, home visits, *hospital inpatient* care, *hospital outpatient* visit/exams, clinic care, and surgical opinion consultations;
  - of registered *nurses* (RNs) or licensed practical *nurses* (LPNs) for private duty nursing;
  - for the treatment or services rendered by a licensed *Physician* or Occupational Therapist under direct supervision of a *Physician* in a home setting or at a facility or institution whose primary purpose is to provide medical care for a covered *Accidental Injury*;
  - of a legally qualified *Physician* or qualified Speech Therapist under direct supervision of a *Physician* for restorative speech therapy for speech loss or impairment due to a covered *Accidental Injury*, or due to surgery performed on account of a covered *Accidental Injury* other than a functional nervous disorder;
  - for professional ambulance service to the *hospital* in an emergency situation when a *Subscriber* is subsequently admitted as an *inpatient*; and transport between medical facilities when *medically necessary*;
  - for drugs requiring the written prescription of a licensed *Physician*; such drugs must be necessary for the treatment of a covered *Accidental Injury*;
  - for radiological services, microscopic tests and laboratory tests;
  - for the processing and administration of blood components, but not for the cost of the actual blood or blood components if replaced;
  - for physical and manipulative therapy when such therapy is part of a *Physician*-approved Home Health Care Plan;
  - for oxygen and other gases and their administration;
  - for electrocardiogram, electroencephalograms, pneumoencephalogram, basal metabolism tests, or similar well established diagnostics generally approved by *Physicians* throughout the United States;
  - for the cost and administration of an anesthetic;

- for dressings, sutures, casts, splints, trusses, crutches, braces, and other necessary medical supplies;
- for rental of a wheelchair, *hospital* bed, ventilator, or other *durable medical equipment* required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less;
- for non-dental *prostheses* and *appliances* including artificial limbs, eyes, or larynx, to replace limbs or eyes lost while covered under the *Certificate*, but not the replacement thereof unless the replacement is necessary because of physiological changes;
- for services of an ambulatory or *outpatient* surgical center;
- for Dental Services rendered by a *Physician* for treatment of an *Injury* to a sound, natural tooth if:
  - The *Injury* is caused by a covered *Accident* sustained while a Subscriber;
  - All treatment is rendered within six (6) months of the covered *Accident*; and
  - All treatment is rendered while a *Subscriber*;
- for hyperalimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery;
- for the services of a qualified physiotherapist;

- *Usual, customary and reasonable* Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health Care Plan*.

  Such expenses include:
  - Part-time or intermittent nursing care by a registered *nurse* (R.N.), a licensed practical *nurse* (L.P.N.), a licensed vocational *nurse* (L.V.N.), or public health *nurse* who is under the direct supervision of a registered *nurse*;
  - Home health aides; and
  - Medical supplies, drugs and medicines prescribed by a *Physician*, and *durable medical equipment* prescribed by a *Physician*.

  Specifically excluded from coverage under the Home Health Care benefit are the following:
  - Services and supplies not included in the *Home Health Care Plan*;
  - Services of a person who ordinarily resides in the *Subscriber's* home, or is a close relative of the *Subscriber*;
  - Transportation services;
  - *Custodial Care* and housekeeping.

  Home Health Care Visit means a visit by a member of a Home Health Care team. Each such visit that lasts for a period of four (4) hours or less is treated as one Home Health Care Visit. lf the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one Home Health Care Visit.

SECTION 4 – LIMITATIONS AND EXCLUSIONS

Limitations and Exclusions Applicable to all Benefits

Coverage hereunder shall not apply to any person who is acknowledged as a statutory employee of the *Sponsor* or any *Subscriber* prior to a claim being filed under the *Certificate*, or to any claim brought by employees of the *Subscriber* who are not considered to be *independent contractors*.

No payment of benefits will be made:

1. for, or in connection with, an *Occupational Disease* or *Cumulative Trauma* arising out of, or in the course of, any employment for wage or profit;
2. for, or in connection with, an *Illness* or an *Injury* if the *Subscriber* is deemed to be an employee and covered under any Workers' Compensation or similar state or federal law;
3. for treatment, services or supplies received in a *hospital* owned or operated by the United States Government;
4. for charges which the *Subscriber* is not legally required to pay or for which no charge or payment would have been required if coverage was not in force;
5. for charges which are in excess of *usual, customary and reasonable* charges; or which are determined to be inappropriate or not *medically necessary*;
6. for, or in connection with, *custodial care*, education or training;
7. for, or in connection with, reconstructive surgery or treatment, except as otherwise specifically provided;
8. for eyeglasses, contact lenses and hearing aids, and examinations for their prescriptions and fitting including charges for surgical procedures for the correction of visual refractive problems (radial keratotomy), except for the replacement of eyeglasses, contact lenses or hearing aids which are damaged in a covered *Accident*;
9. for nursing, medical or surgical care or treatment rendered by a family member, including, but not limited to, a spouse, child, mother, father, brother, sister, parent of spouse, aunt, uncle, or son-in-law/daughter-in-law;
10. for, or in connection with, dental services or supplies, except as provided for herein;
11. to the extent that the *Subscriber* is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any government sponsored program, including, but not limited to, *Medicare* or Social Security;
12. for any loss directly resulting from the commission of or attempt to commit a felony or directly resulting from being engaged in an illegal act or occupation;
13. as a direct or indirect result of war (whether declared or not), invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolution, terrorism, insurrection, military or usurped power or confiscation or nationalization;
14. for nuclear reaction, nuclear radiation or radioactive contamination;
15. for devices, equipment and supplies that are not *durable medical equipment or prostheses*, except as otherwise specifically provided;

16. for services paid, payable or required to be provided as Basic Reparations Benefits under any No-Fault Automobile Insurance Law except as provided herein. An uninsured or underinsured motorist will be considered self-insured for *bodily injury* expenses. The *Insurer* will not be required to extend benefits which are required under any No-Fault Automobile Insurance Law;
17. for, or in connection with, *experimental* procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
18. for *experimental* drugs or substances not approved by the Food & Drug Administration, or for drugs labeled: *"Caution: Limited by Federal Law to Investigational Use"*;
19. for non-medical *hospital* expenses such as newspapers, guest trays, beauty shop services, cots, guest accommodations, admission kit, rental of telephones, radios, televisions or any other items solely for personal use or comfort;
20. for care, treatment, services, supplies, materials, and/or equipment that is not *medically necessary* or that is inappropriate for the diagnosis and related care/treatment of a covered *Accidental Injury*;
21. by any provider of medical services for the time spent traveling in the course of rendering medical care;
22. for the services of nutritionists, acupuncturists, massage therapists, herbalists, whether or not they are licensed or certified. For the services of any other allied or alternative health professionals that are unlicensed;
23. for suicide, attempted suicide or self-inflicted *Bodily Injury* while sane or insane;
24. for failure to attend or remain at scheduled visits and charges for copying or completion of any claim form, operative report or medical records;
25. for a *Bodily Injury* while the *Subscriber* is:
    - Intoxicated (a *Subscriber* will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the covered *Accident* occurred, to be under the influence of alcohol or intoxicating liquid if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the *Bodily Injury* is sustained); or
    - Under the influence of a narcotic or controlled substance, unless prescribed by a *Physician* and taken in accordance with the prescribed dosage;
26. for medical care or treatment received while incarcerated in a local, state or federal facility (benefits as shown on the **Schedule** will be terminated as of the first day of incarceration);
27. for *sickness*, disease or bacterial or infections;
28. for purposely self-inflicted *Injury* or any *Injury* resulting from a provoked attack;
29. for any *Bodily Injury* incurred while riding or driving in any kind of organized race for profit;
30. for any *Bodily Injury* incurred during travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,
    - while being used for any test or *experimental* purpose; or
    - while a *Subscriber* is operating, learning to operate or serving as a member of the crew thereof; or
    - while being operated by or for or under the direction of any military authority, other than transport type aircraft;

31. when skydiving, parasailing, bungee-jumping, or doing any similar activity: or
32. for prostatitis or hemorrhoids not directly related to a covered *Accident*; or
33. for any amount of a covered claim that exceeds the Combined Single Limit. The Combined Single Limit is shown in the **Schedule**; or
34. for *Pre-existing Conditions*. The term *Pre-existing Condition* means an *illness* or *injur*y for which a covered *Subscriber*:
    - Incurred charges,
    - Received medical treatment,
    - Consulted a physician, or
    - Took prescribed drugs

    within 12 months before he or she became insured under a given benefit section of the policy.

SECTION 5 – CLAIMS PROVISIONS

UTILIZATION MANAGEMENT

Utilization Management is a proven strategy for containing health care costs. The goal of utilization management is to reduce the incidence of *medically unnecessary* and inappropriate *Physician* care, surgical procedures, or *hospital* admissions through a *pre-certification* process.

These Terms and Conditions provide for the utilization of *Physicians* and health care professionals to determine the medical necessity and appropriateness of procedures and review claims submitted for reimbursement. All *Physicians* and *hospitals* will be informed of this process as applicable. If questions arise regarding Utilization Management requirements, please call the utilization review provider. Questions will be answered professionally and confidentially by specially trained staff.

CLAIMS HANDLING

TOA will designate a Claims Administrator to: (a) complete a Call-In sheet logging the *Subscriber's* answers to the Call-In sheet's questions; (b) send to the Subscriber the initial claim forms and an Injury Letter explaining the *Subscriber's* obligations; and (c) assist the *Subscriber* in submitting the initial claim forms. The *Insurer* will designate a Claims Administrator who shall be responsible for the remainder of the claims processing. Claim forms are to be submitted directly to the *Insurer's* Claims Administrator.

Currently, TOA has designated All United Risk Managers LLC ("All United") as its Claims Administrator and the *Insurer* has designated Gallagher Bassett Services Inc ("Gallagher Bassett") as its Claims Administrator. Completed claim forms are to be submitted directly to the Gallagher Bassett.

If a *Physician* or other provider is submitting a claim where benefits have been assigned, he or she may use any standard or generally accepted claim form. The claim form must be completed and accompanied by an itemized bill that shows specific services, dates of service, and other information in detail.

If there is any question with regard to *Subscriber* eligibility, continuance of coverage, payment of a claim, or if there is a dispute with the denial of a claim or the amount paid, contact should first be made with the *Insurer's* Claims Administrator and then with TOA. The *Subscriber* is allowed at least 60 days to request a review of the claim. The *Subscriber* has the right to review pertinent documents affecting the acceptability of a claim and to submit comments in writing. The review of the claim is normally made within 30 days after receipt of a request for review. An additional 30 days will be allowed if special circumstances require more time. A notice in writing will be sent before the expiration of the initial 30-day period if an extension is needed. The decision on a review will be sent in writing. It will include specific reasons for the decision and will refer to pertinent Certificate provision, Terms & Conditions or legal provisions on which the decision was based.

FRAUDULENT CLAIMS

Filing a false or misleading claim for benefits is a FELONY and is punishable by a fine and/or imprisonment. TOA and the *Insurer* have the right, but not the duty, to prosecute any person or organization who they believe may have filed for and/or received benefits as a result of filing a false or misleading claim for benefits. TOA and the *Insurer* may also prosecute, at their sole discretion, any individual who they believe may have aided or assisted in the filing of a false or misleading claim. If a claimant is later found to be guilty of filing a false or misleading claim, the *Insurer* shall be relieved of any unpaid benefits otherwise due under the *Certificate* and shall pursue repayment from the *Subscriber* or to any other parties for amounts already paid as may be permissible by law.

CLAIM FORMS

Upon receipt of a notice of claim, TOA's Claims Administrator will furnish to the *Subscriber* the required claim forms. The *Subscriber* shall complete the forms and submit them directly to the *Insurer's* Claims Administrator who shall be responsible for the remainder of the claims processing. It is the *Subscriber's* responsibility to advise TOA and TOA's Claims Administrator if the claim forms are not received within five (5) calendar days..

NOTICE OF CLAIM

Written notice of claim must be given to Gallagher Bassett within ninety (90) days after the occurrence or commencement of any loss covered by the *Certificate* or as soon after the loss as is reasonably possible.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the date of issue of the *Certificate*, no misstatement made by any *Subscriber* in the application for this insurance shall be used to void the *Certificate* or to deny a claim for loss *Incurred*, as defined herein, commencing after the expiration of such two (2) year period.

TIME OF PAYMENT OF CLAIMS

All benefits payable under the *Certificate* will be payable immediately upon receipt of due written proof of such loss. Should the *Insurer* fail to pay the benefits payable under the *Certificate* upon receipt of due written proof of loss, the *Insurer* shall have thirty (30) days thereafter within which to mail a letter or notice which states the reasons the *Insurer* may have for failing to pay the claim, either in whole or in part, and which also gives a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the *Insurer* shall then have thirty (30) days within which to process and either pay the claim or deny it, in whole or in part, stating the reasons the *Insurer* may have for denying such claim or any portion thereof. The *Insurer* shall pay interest as required by law on the benefits due under the terms of the *Certificate* and these Terms & Conditions for failure on the *Insurer's* part to comply with the requirements of this provision.

SUBROGATION

To the extent that benefits are paid under the Policy, the *Insurer* shall be subrogated to all rights of recovery which any *Subscriber* may acquire against any other party for the recovery of the amount paid under the Policy, however the *Insurer's* right of subrogation is secondary to the right of the *Subscriber* to be fully compensated for his or her damages. The *Subscriber* must deliver all necessary documents or papers, execute and deliver all necessary instruments, furnish information and assistance, and take any action the *Insurer* may require to facilitate enforcement of the *Insurer's* right of subrogation. The *Insurer* agrees to pay the *Insurer's* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that the *Insurer* recovers any portion of the benefits paid under the Policy pursuant to the *Insurer's* right of subrogation.

RIGHT OF REIMBURSEMENT

To the extent that benefits are provided or paid under the Policy, if a *Subscriber* fully recovers his damages from a third party, then he will reimburse the *Insurer* the portion of the damages recovered for the expenses incurred by the *Subscriber* that were provided or paid by the *Insurer*. The *Insurer* agrees to pay the *Insurer's* portion of the *Subscriber's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that the *Insurer* recovers any portion of the benefits paid under the Policy pursuant to the *Insurer's* right of reimbursement.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the duplication or overpayment of benefits for eligible expenses *Incurred*. It applies when a *Subscriber* is also covered by any other certificates or policies. When more than one coverage exists, one coverage normally pays its benefits in full and the other coverage pays a reduced benefit. The *Insurer* will always pay either benefits in full or a reduced amount which when added to the benefits payable by the other certificates or policies, will not exceed 100% of *Allowable Expenses*. Only the amount paid by the *Insurer* will be charged against the *Subscriber's* maximums indicated in the **Schedule**.

Allowable Expense: *Allowable expenses* as used herein means the *usual, customary and reasonable* expenses 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;
- any individual medical policy or coverage.

If an arrangement has two parts and the Coordination of Benefits rules apply only to one of the two, each of the parts is considered a separate plan.

Primary Plan: When the *Insurer's* Plan is primary, the *Insurer's* benefits are determined before those of the other policy. The benefits of the other policy are not considered.

Secondary Plan: When the *Insurer's* Plan is secondary, the *Insurer's* benefits are determined after those of the other policy. The *Insurer's* benefits benefits may be reduced because of the other policy's benefits.

The following "Order of Benefit Determination" establishes when the *Insurer's* Plan is the Primary Plan or Secondary Plan in relation to any other plans covering the *Subscriber*. When there are more than two Plans covering the *Subscriber*, the *Insurer's* Plan may be either a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan(s).

ORDER OF BENEFIT DETERMINATION:

The *Subscriber's* coverage under the *Certificate* will be the Primary Plan in all cases except for the following:

1. when any coverage is available under the federal Social Security Act or similar law; or
2. when *Medicare* is primary; or
3. when the *Subscriber* qualifies for Workers' Compensation or any other similar statutory program.

Right to Receive and Release Needed Information – The *Insurer* may, at its sole discretion, give or receive any information that the *Insurer* needs to underwrite, investigate and/or settle claims under this insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions or nonmedical information about the *Subscriber's* family or the *Subscriber* is authorized to release such information to the *Insurer* or its designee. This includes information related to substance use or abuse. Any medical practitioner, medical facility, pharmacy, the Medical Information Bureau (MlB), employer or insurance company that may have such information is authorized to release

such information to the *Insurer* or its designee. The *Insurer* or its Claíms Administrator may also release this information about the *Subscriber's* family or the *Subscriber* to the MIB or any insurer to which the *Subscriber* has applied for coverage or to anyone else the *Insurer* or its Claíms Administrator deems necessary to investigate and/or settle a claim under this insurance.

SECTION 6 – DEFINITIONS

Accident or Accidental Injury: The term *Accident* or *Accidental Injury* means an unforeseen event, or series of events, which results in *Bodily Injury*.

This event must meet all of the following:

- It must happen while the *Subscriber* is covered under this Plan;
- It must be an *Occupational Accident*;
- The *bodily injury* must result directly from the covered *Accident* and must be independent of an *Occupational Disease*, ordinary disease of life or bodily infirmity;
- It must be an event which was unforeseen, unplanned and unexpected;
- It must have occurred at a specifically identifiable time and place;
- It must have occurred by sudden and abrupt cause or by chance;
- It must have resulted in *physical Injury* to a *Subscriber*;
- It must have arisen out of and in the course of a *Subscriber's* duties under a *Covered Contract*; and
- It must have occurred during the Coverage Period.

Accident or Accidental Injury **does not** include any of the following:

- Aggression in a fight; or
- Suicide or attempted suicide; or
- An *illness or sickness*; or
- *Cumulative trauma*; or
- *Occupational disease*; or
- Hernia of any type.

Ambulatory Care Facility: The term *ambulatory care facility* means a facility equipped to handle surgical procedures that require *hospital*-type facilities, but do not require *hospital confinement*. In order to qualify, an a*mbulatory care facility* must:

- be established, equipped and operated for the performance of surgical procedures by *Physicians* who are part of an organized medical staff; and
- have equipment and supplies not usually available to a *Physician* outside a *hospital* including operating rooms, recovery room, diagnostic facilities, emergency equipment and full-time *Nurses*; and
- have a written agreement with a nearby *hospital* to accept patients who develop complications and require *hospital confinement*.

Ambulatory Surgical Center: The term *ambulatory surgical center* means an institution or facility, either free-standing or as part of a *hospital* with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and from which he or she is discharged within a twenty-four (24) hour period. An office maintained by a *Physician* for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, is not an *ambulatory surgical center*.

Average Weekly Compensation: The term *average weekly compensation* means either of the following:

- The *Subscriber's* net earnings as reported to the Internal Revenue Service on Form Schedule C for the twelve (12) calendar months immediately preceding the date of the covered *Accident*, divided by 52. If the period of time worked is less than one year, the *Insurer* will take the average of the total consecutive weeks worked as an *Independent Contractor*.

- 75% of the gross settlements earned by the *Subscriber* and reported on Form 1099 for the twelve (12) calendar months immediately preceding the date of the covered *Accident*, divided by 52 weeks. If the period of time worked is less than one full year, then the average of the total consecutive weeks worked as an *Independent Contractor* will be used to establish the gross settlement amount and then adjusted by the 75% factor for offsetting expenses and operating costs incurred by the *Independent Contractor*.

This *average weekly compensation* amount will then be used to calculate the benefit amount payable as defined in the **Schedule** section of this policy.

Bodily Injury: The term *Bodily Injury* means an *Occupational Accident* resulting in *physical injury* to a *Subscriber* which occurs during the *Coverage Period* and while the *Subscriber* is under contract and arises solely out of and in the course of his/her occupation and duties as defined in the *Covered Contract* as an *Independent Contractor*.

Certificate: The term *Certificate* means the Certificate of Insurance issued by TOA.

Convalescent or *Skilled Nursing Facility*: The term *convalescent* or *skilled nursing facilit*y means an institution or distinct part thereof, operated pursuant to law and meets all of the following conditions:

- It is licensed to provide, and is engaged in providing on an *inpatient* basis, for persons convalescing from *injury*, nursing services rendered by a Registered *Nurse* (R.N.), a Licensed Practical *Nurse* (L.P.N.), or a licensed vocational *Nurse* (L.V.N.) under the direction of a Registered *Nurse* and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential activities of daily living; and
- Its services are provided for compensation from its patients and under the full-time supervision of a *Physician* or Registered *Nurse*; and

- It provides 24-hours per day nursing services by licensed *nurses*, under the direction of a full-time Registered *Nurse*; and
- It has a Medical Director and/or has a *Physician* who visits the facility and its patients on a regular basis; and
- It maintains a complete medical record on each patient; and
- It is not, other than incidentally, a place for rest, custodial or educational care, the care of mental disorders, the care and treatment of substance abuse, or a home for the aged; and
- It is approved and certified by *Medicare*.

This term shall also apply to expenses *Incurred* in an institution referring to itself as an *Extended Care Facility*, *Convalescent Care Facility*, Nursing Home or any such other similar nomenclature.

Convalescent Period: The term *convalescent period* means a period of time commencing with the date of confinement to a *Convalescent* or *Skilled Nursing Facility*. Such confinement must meet all of the following conditions:

- Such confinement must commence within fourteen (14) days of being discharged from a *hospital*; and
- Said *hospital confinement* must have been for a period of not less than three (3) consecutive days; and
- Both the *hospital* and *convalescent* confinements must have been for the care and treatment of the same covered *injury*.

The *convalescent period* will terminate when free of confinement in any and all institutions providing *hospital* or nursing care for a period of ninety (90) consecutive days. A new *convalescent period* shall not commence until the previous *convalescent period* has terminated.

Cosmetic Procedure: The term *cosmetic procedure* means a procedure performed solely for the improvement of a *Subscriber's* appearance and not for the improvement or restoration of a bodily function.

Coverage Period: The term *coverage period* means a continuous period of time that begins on the *Subscriber's Enrollment Date* and continues until coverage terminates as per the *Certificate* and these Terms & Conditions. Such benefit period will terminate on the earliest of the following dates:

- the day any Maximum Benefit applicable to a *Subscriber* is paid; or
- the day a *Subscriber* ceases to be covered under the *Certificate* and these Terms & Conditions.

Covered Contract: The term *covered contract* means a legal, written work agreement that meets state *Independent Contractor* requirements and definitions as further defined in the Covered Activity Rider.

Cumulative Trauma: The term *cumulative trauma* means an *injury* diagnosed by a *Physician* as occurring without *Accidental Bodily Injury* being the direct cause of loss. *Cumulative trauma* includes *injury* caused by continual stress and strain. Such *injury* may be causally related to a person's job. Such *injury* may be due to repetitive traumatic acts. Hernia is not considered to be cumulative trauma.

Custodial Care: The term *custodial care* means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a *Subscriber*, whether or not *totally disabled*, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision of medication which can normally be self-administered.

Durable Medical Equipment: The term d*urable medical equipment* means equipment which is:

- able to withstand repeated use;
- primarily and customarily used to serve a medical purpose; and
- not generally useful to another individual or an otherwise healthy individual.

Examples of *durable medical equipment* include, but are not limited to: wheelchairs, ventilators, *hospital* type beds, etc. Examples of equipment which do not meet the definition of *durable medical equipment* include, but are not limited to: humidifiers, safety bars or other similar apparatus that assist in the activities of daily living, exercise bikes or equipment, orthopedic shoes or lifts, saunas, spas, hot tubs, etc.

Emergency Care: The term *emergency care* means those procedures or services due to *Accidental Injury* or an illness that results from a covered *Accidental Injury* that requires immediate medical attention.

Experimental: The term *experimental* means services and supplies which are experimental or investigational in nature, meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not generally recognized as accepted medical practice and includes any such services or supplies requiring Committee approval not granted at the time of service.

Home Health Care Agency: The term *home health care agency* means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

- it is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing and other therapeutic services; and
- it has policies established by a professional clinical group associated with the agency or organization; this group must include at least one *Physician* and at least one Registered *Nurse* (RN) to govern the services provided; and
- it must provide for full-time supervision of such services by a *Physician* or Registered *Nurse*; and
- it maintains complete medical records; and
- it has a full-time administrator.

Home Health Care Plan: The term *home health care plan* means a program for care and treatment established and approved by the attending *Physician*, which provides for coordinated care in the home which is *medically necessary*.

Hospital: The term *hospital* means an accredited institution which is approved as a *hospital* by the Joint Commission of the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria;

- It is primarily engaged in providing, for compensation from its patients and on an *inpatient* basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of *Physicians*. If primarily a facility for the treatment of mental and/or psychological conditions, or chemical dependency, such facility must have a bona fide arrangement by contract or otherwise with a *hospital* to perform such surgical procedures as may be required; and
- it continuously provides twenty-four (24) hours per day nursing services by Registered *Nurses* under the supervision of *Physicians*; and
- it is not, other than incidentally, a place for rest, the aged, a nursing home, a hotel or the like.

Hospital Confinement: The term *hospital confinement* means a stay as a *registered bed patient* in a *hospital* for twenty-four (24) hours or longer. A *registered bed patient* is one assigned to a bed in any department of a *hospital* except the *outpatient* department, and who is charged for room and board. The stay must be recommended by a *Physician* for a *medically necessary purpose*. The patient cannot leave the *hospital* during the stay.

Illness or Sickness: The terms *illness or sickness* means a bodily disorder, disease, physical illness or psychiatric disorder. *Illness/sickness* also includes pregnancy.

Incurred: The term *incurred* means the date on which care, treatment, services or supplies are rendered or supplied.

Incurred Expenses: The term *incurred expenses* means the cost of services and supplies rendered or supplied. Such expenses are considered *incurred* at the time or date the service or supply is actually provided.

Independent Contractor: The term *independent contractor* means a *Subscriber* who meets the specific legal definitions and requirements as set forth in the applicable State law for an *Independent Contractor*. The following criteria represent the minimum requirements for an *Independent Contractor*:

1. performs work under a formal written work agreement or contract defined as a *Covered Contract*; and
2. receives compensation reported under a Form 1099 for compensation and self-employment tax purposes; and
3. has responsibility for determining the time, means and method of performing the work required under a *Covered Contract*; and
4. cannot be an employee of the *Sponsor* or of any scheduled Additional Insured parties covered under the *Certificate*.

Injury: See *Accident*, *Accidental Injury* or *Occupational Accident*.

Inpatient: The term *inpatient* means a person who is admitted to a *hospital* and who is confined to bed for health care.

Insurer: means the Underwriters or Insurance Company identified on the Schedule as the underwriter of this insurance.

Medically Necessary: The term *medically necessary* means those medical services, supplies or treatment authorized by a *Physician* to treat the *Subscriber's* covered *Accidental Injury* which are:

- consistent with the symptoms or diagnosis; and
- appropriate and accepted according to good medical practice standards; and
- consistent with the most appropriate supply or level of service which can safely be provided to the patient.

Medicare: The term *Medicare* means all benefits under Part A and/or Part B of Title XVIII of the Social Security Act of 1965 as may be amended from time to time.

Nurse: The term *nurse* means an individual who has received specialized nursing training and is authorized to use the designation "RN" Registered *Nurse*, "LPN" Licensed Practical *Nurse* or "LVN" Licensed Vocational *Nurse*, and who is duly licensed by the state or regulatory agency responsible for issuing such license in the appropriate jurisdiction.

Occupational Accident: The term *occupational accident* means a covered *Accident* resulting in *Bodily Injury* sustained within the time frame indicated in the **Schedule** and *Certificate* and which meets all of the following criteria and stipulations:

- it must happen while the *Subscriber* is engaged in the duties as defined in the *Covered Contract* with the *Sponsor*; and
- engaged in a covered activity as defined herein; and
- it must happen while the *Subscriber* is covered under this plan; and
- the *Bodily Injury* must result directly from the covered *accident* and be independent of any *Occupational Disease*, ordinary disease of life or bodily infirmity.

Occupational Accident **does not** include any of the following:

- aggression in a fight;
- a *sojourn or personal deviation*;
- suicide or attempted suicide;
- *Cumulative Trauma*;
- *Occupational Disease*;
- Hernia of any type.

Occupational Disease: The term *occupational disease* means an *illness* arising out of a *Subscriber's* duties under a *Covered Contract* which causes damage or harm to the physical structure of the body. *Occupational disease* does not include ordinary *illnesses* of life to which the general public is exposed

outside of the *Subscriber's* duties defined within a *Covered Contract* or an *illness* resulting directly from a covered *Accident*.

Outpatient: The term *outpatient* means a person who is not admitted as an *inpatient* but who receives health care, services or supplies.

Physician: The term *Physician* means a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), chiropractor (D.C.), podiatrist (D.P.M.), dentist (D.D.S. or D.M.D.), optometrist (O.D.), psychologist (Ph.D.), licensed independent clinical social worker (L.I.C.S.W.), registered *nurse* clinical specialist (R.N.C.S.), any other licensed practitioner including *Nurse* practitioners, *Physician* assistants, *Nurse* midwives, *Nurse* anesthetist. A *Physician* must be acting within the scope of their license. This definition does not include someone who ministers to a *Subscriber* that is related to the *Subscriber* by blood, marriage or adoption or who is normally a member of the *Subscriber's* household.

Policy: The term "Policy", also referred to as "Group Policy" means the contract between the *Insurer* and the *Policyholder* under which *Sponsors* can provide insurance benefits to Subscribers.

Policyholder: The term *Policyholder* means TOA, the organization named in **Item #1 of the Schedule**. TOA is the *Policyholder* of the master policy issued by the *Insurer*. The *Policyholder* may request cancellation of the *Group Policy*, negotiate terms and conditions, request changes in coverage or amounts of insurance and request termination of all *Certificates*.

Pre-admission Testing: The term *pre-admission testing* means the actual charges made by a *hospital* for services rendered on an *outpatient* basis which are *medically necessary* prior to scheduled *inpatient* confinement at the same facility.

Pre-existing Conditions: The term *pre-existing conditions* means an *illness* or *injury* for which a covered *Subscriber*:

- incurred charges;
- received medical treatment or advice;
- consulted a *Physician*; or
- took prescribed drugs,

within 12 months before the effective date he or she became insured under a given benefit section of this *Policy*.

Prescription Drug: The term *prescription drug* means any drug, under applicable state law, that is dispensed only with a written prescription from a *Physician* and has a label bearing the legend: "Caution: Federal law prohibits the dispensing without a prescription." It is also any mixed medicine with at least one ingredient bearing the above legend.

*Prosthesis (*or *Appliance)*: The term *prosthesis* means a device to replace natural body parts or limbs; *appliance* means a device or instrument used to assist an infirmed person in ambulating (e.g., walker, cane, crutches) or which is used to remedy a chronic condition.

Rehabilitation Facility: The term r*ehabilitation facility* means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitation facility* for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission on the Accreditation of Health Care Organizations or the Joint Commission for the Accreditation of Rehabilitation Facilities or similar group or organization.

Sojourn/Personal Deviation: The terms *sojourn* or *personal deviation* means any personal deviation that takes away from, or interferes with the dispatched activities of the *Sponsor*.

Sound Natural Tooth: The term *sound natural tooth* means a tooth that has no fillings or cavities, or the fillings or cavities do not undermine the tooth cusps; the pulpal tissues are healthy and intact; and the periodontal tissue shows little or no signs of active or chronic inflammation.

Sponsor: The term *Sponsor* means a person or organization named in **Item #3 of the Schedule** that applies for coverage under the *Group Policy*. A *Sponsor* must complete an Application Agreement agreeing to these Terms and Conditions and all requirements and terms specified and approved by the *Insurer*.

Sponsor Effective Date: The term *Sponsor effective date* means the date/time designated in writing by the *Insurer* and/or TOA for the *Sponsor's* participation under the Policy to begin.

Subscriber: The term *Subscriber* means a person who is either: a) a bona fide member of the *Sponsor* – if the *Sponsor* is an association, or b) an individual *Independent Contractor* of a *Sponsor* who has applied to be a *Subscriber* under the *Group Policy*. To be a *Subscriber*, a person must first:

- meet the eligibility requirements for coverage; and
- be *validly enrolled*; and
- be contracted with a *Sponsor* covered under the *Group Coverage*.

A *Subscriber's* coverage will not start until the effective date stated in the *Certificate* issued by TOA. However, if the *Subscriber* is away from work because the *Subscriber* is disabled on the date coverage would start, coverage will not start until the *Subscriber* is no longer disabled and returns to active work, but only if he/she returns to active work before the expiration date stated in the *Certificate*.

Subscriber's Enrollment Date: The term *Subscriber's enrollment date* means the the effective date on which the *Subscriber's* insurance begins as stated in the *Certificate* issued by TOA. However, if the *Subscriber* is away from work because the *Subscriber* is disabled on the date coverage would start,

coverage will not start until the *Subscriber* is no longer disabled and returns to active work, but only if he/she returns to active work before the expiration date stated in the *Certificate*.

Usual, Customary And Reasonable: The term *usual, customary and reasonable* means the lesser of:

- the *usual* fee - the charge most frequently made for the covered services or supplies by a *Physician* or *hospital*;
- the *customary* fee - the charge made for covered services or supplies by those of similar professional standing in the same geographic area;
- the *reasonable* fee - the charge determined by considering the complexity involved, the degree of professional skill required and other pertinent factors, if the first two methods above cannot be easily determined.

Valid Enrollment: The term *valid enrollment* means coverage is validly in force only if the enrollment information supplied to TOA, the *Insurer*, the *Insurer's* Claims Administrator and TOA's Claims Administrator is correct. The only way coverage can be in force is if information provided regarding the *Subscriber* is accurate, complete, legible and signed. No one is authorized to waive this requirement without prior written consent from the *Insurer* or its Administration.

Valid and Collectible Insurance: (Applies when the *Insurer's* coverage is subject to the Coordination of Benefits provision.) The term *valid and collectible insurance* means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following plans covering the *Subscriber*:

- for individuals in a group whether on an insured, self-insured, or uninsured basis, such as group, blanket or franchise insurance, prepayment plans or any other plan arranged through any school, employer, trustees, association, union or employee benefit association, including individual policíes which are not exclusively health policies; or
- provided under government programs; or
- required or provided by any federal, state or local law, except Medicaid or *Medicare*; or
- workers' compensation or similar statutory coverage.

Waiting Period: The term *waiting period* means a period of time a *Subscriber* must be continuously disabled before benefits are payable.

You, Your and Yours: The terms *You*, *Your* or *Yours* refer to the *Sponsor*.

SECTION 7 – GENERAL PROVISIONS

1. **Entire Contract.** Upon acceptance by TOA, the Application, these Terms & Conditions, the *Policy*, the *Certificate*, and all forms and documents related to the coverages indicated in the *Certificate*, represent the complete and entire Contract between TOA and the *Sponsor*. TOA has made no representations or warranties except as expressly set forth therein.

2. **(a) Request for Insurance.** TOA will provide an Application to entities that wish to become *Sponsors* to enroll *Subscribers*, along with any other forms TOA or the *Insurer* requires to start coverage. TOA will also provide to current *Sponsors* a form for requesting the enrollment of additional *Subscribers*. The *Sponsor* or would-be *Sponsor* must submit these documents and they must be accurate, complete, legible and signed. The only way coverage can be in force is if the *Sponsor* or would-be *Sponsor* accurately includes all information asked for in the Application and forms.

   (b) Misstatement of Age. If the wrong age of a *Subscriber* is given and the coverage or premium is affected by age, the coverage and/or premium will be adjusted accordingly. 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 *Subscriber's* true age. Any such misstatements of age will not have an affect on insurance otherwise validly in force.

   (c) Misstatement of Eligibility. TOA and the *Insurer* reserve the right to refund any premiums reported and paid on any insured who is found to not meet the definitions of a *Subscriber* in these Terms & Conditions. The inadvertent receipt of any such premiums will not obligate TOA or the *Insurer* to any potential claims. Upon determination of such receipt, TOA or the *Insurer* will refund those specific premiums within a reasonable amount of time.

   (d) Time Limit for Reporting Changes in Covered Subscribers. The *Sponsor* must report changes in covered *Subscribers* to TOA and the *Insurer* by the end of each week. The *Insurer* or TOA, at their sole discretion, may choose to not honor any changes not reported within sixty (60) days of the date of such change.

3. **Workers' Compensation.** The *Certificate* and the benefits are not in lieu of, nor shall affect any requirements for coverage under any Workers' Compensation law or other similar law.

   If a *Subscriber* is **not subject to Workers' Compensation laws** or is **not eligible for Workers' Compensation benefits** as an *Independent Contractor* and if coverage for *Occupational Injuries* is extended to a *Subscriber*, benefits under this insurance will be payable for any covered *accidental injury*.

4. **Benefits and Examination Determination.** Binding decisions regarding benefits covered and payable are made by the *Insurer*. No benefits are payable for services, supplies or treatment that are not *medically necessary* and appropriate. In the course of *Pre-certification* and/or *Utilization Management*, the *Insurer* may require that a *Subscriber* be examined by a *Physician* of the *Insurer's* choosing, at the *Insurer's* expense. If a *Subscriber* refuses, the claims in question may be denied.

5. **Physical Exam and Autopsy.** The *Insurer* shall have the right and opportunity to examine any *Subscriber* when and as often as the *Insurer* may reasonably require during the pendency of a claim. The *Insurer* shall have the right to access an autopsy report in case of death where it is not forbidden by law.

6. **Inadvertent Error.** At *Insurer's* sole discretion, the failure of a *Sponsor* or *Subscriber* to transmit, report, pay premium or comply with any of the provisions of the *Certificate* or these Terms & Conditions, when such failure is due to an inadvertent error or clerical mistake, will not prejudice the insurance of a *Subscriber*.

7. **Age Limit.** Benefits payable under the *Certificate* shall only apply to covered *Subscribers* prior to attaining the Age Limit shown in the **Schedule**. If the *Subscriber* reaches the Age Limit during a *coverage period*, AD&D benefits shall be reduced based on the Reduction of Benefits Table outlined next in **#14. Benefits for Subscribers Over Age 65.**

8. **Benefits for Subscribers Over Age 65.** Benefits provided by the *Certificate* can be extended to a *Subscriber* over the age of 65 on a **"Named"** basis only. The *Subscriber* must qualify for and be approved by the *Insurer's* Administrator before this extension of benefits will apply. The *Subscriber* must submit a Request for Extended Benefits and supply any required underwriting information including, but not limited to, an attending Physician's statement, if required. The Administrator will advise the specifically *Named Subscriber* in writing of any approval or disapproval of any request for extensions of benefits.

   Extended Benefits. The benefits extended to *Subscribers* over the age of 65 shall consist of Accidental Death & Dismemberment, Accidental Disability (limited to Temporary Total Disability benefits for a maximum of two years) and Accident Medical benefits. **No benefits are provided for Permanent Total Disability.** The *Subscriber's* premium when 65 or older is based on 100% of the coverage that would be in effect if the *Subscriber* were under age 65. "AGE" as used above refers to a *Subscriber's* age on their most recent birthday, regardless of the actual time of birth.

   Reduction of Benefits Table. The amount payable for any AD&D loss will be reduced when a *Subscriber* is age 65 or older. The AD&D amount payable will be reduced by the applicable percentage shown in the following table:

AGE ON DATE OF ACCIDENT	% OF PRINCIPAL SUM
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

9. **Assignment of Benefits.** Payments for Disability may be assigned to a third party as indicated on an Assignment of Benefits Form provided by the *Insurer*. The form must be completed, signed and approved by the *Insurer* and the third party before it will take effect. Benefits paid under this Assignment of Benefits Provision will be deducted from the total amount of benefits payable to the eligible *Subscriber*.

COVERED ACTIVITY ENDORSEMENT
TRUCKING OPERATION

This ENDORSEMENT is to be attached to and forms a part of the Certificate of Insurance shown below issued by Participating Lloyd's Underwriters to the Policyholder shown below.

Effective Date: 01/02/2017
Policy Number:
Named Insured: Truck Owners Association

Insurance under the Certificate of Insurance is provided to covered *Subscribers* participating under the Named Insured shown above and while engaged in the Covered Activity as specified hereon.

Coverage is applicable while the *Subscriber* is performing the regular duties of an *Owner/Operator* truck driver, scheduled co-driver or scheduled *Contract Driver* as defined below while *under dispatch* pursuant to a *covered contract*.

Owner/Operator is a Person who meets all of the following criteria:
- Is an *independent contractor* as defined by law; and
- Is responsible for determining the time, means and method of performing the work; and
- Has entered into a *covered contract* with the Named Insured for the leasing of the Owner/Operator's truck; and
- Is compensated on a Form 1099 and not a Form W-2; and
- Does not own or control the *Sponsor*.

Contract Driver is a driver who drives a motor vehicle owned or leased by an *Owner/Operator* or the Named insured. A *Contract Driver* cannot be an employee of the Named Insured or the *Owner/Operator*. The *Contract Driver* must meet all of the following criteria:
- Is an *independent contractor* as defined by law; and
- Works under a *covered contract* that provides for possible financial loss or gain by the *Contract Driver* relative to the operation of the truck being utilized; and
- Is responsible for determining the time, means and method of performing the work; and
- Is compensated on a Form 1099 and not a Form W-2.

Under Dispatch is the period of time the *Subscriber* operates a truck. This includes all of the following:
- In route to pick up a load;

- Picking up a load;
- In route to deliver a load;
- Unloading a load;
- In route to pick up another load;
- The waiting time for a load if the *Subscriber* is not at home;
- Returning to a terminal or home after delivering a load, whichever occurs first; and
- Performing truck repair.

Nothing in this Endorsement shall be held to alter, vary or affect any of the terms, provisions and conditions of said Certificate of Insurance other than as above stated.

CONTINGENT LIABILITY BENEFITS ONLY

TABLE OF CONTENTS

IMPORTANT NOTICE

IMPORTANT NOTICE: THIS IS NOT A COVERAGE OF WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION OBLIGATIONS.

SCHEDULE

This Schedule is a very brief summary of the Contingent Liability Benefits. Please read the entire Terms & Conditions for a more complete description of the benefits outlined in this Schedule.

TOA and the Insurer certify that a Group Policy providing Contingent Liability coverage has been issued

to TOA, bearing the Policy number shown in **Item # 2** of this **Schedule**.

Item 1. Master *Policyholder*: Truck Owners Association

Item 2. Policy Number: R170017, underwritten by Certain Underwriting Members of Lloyd's of London.

Item 3: Named Insured Number:

Item 4: Named Insured:

Item 5: Named Policyholder Effective Date: 1st February 2017 12:01 A.M., Standard Time at the address of the Policyholder.

Item 6: Named Policyholder Expiration Date: 1st February 2018 12:01 A.M., Standard Time at the address of the Policyholder.

Item 7. Additional Conditions and Limitations:

1. Premium Payment Mode:	Monthly
2. Premium Calculation Mode:	15th of the Month
3. Age Limit (see General Provisions for more details)	Age 65

Amount of Insurance

Item 8. Contingent Liability Coverage

1. Limit of Liability any one Covered Person / Subscriber:	$500,000
2. Limit of Liability any one Occurrence:	$1,000,000

Contingent Liability Coverage

THIS COVERAGE PART CONTAINS BOTH A SUNSET PROVISION FOR REPORTING CLAIMS AND A COMMUTATION PROVISION FOR SETTLING CLAIMS, PLEASE READ CAREFULLY.

In return for the payment of premium, the Insurer agrees to provide this Contingent Liability Coverage to the Named Insured. Coverage is provided during the period listed in the Certificate issued by TOA.

Various provisions in this Coverage part restrict Coverage. This Coverage is contingent on the occurrence of specified events. A covered contingency will occur when the Sponsor receives notice of a claim for Occupational Bodily Injury by a Subscriber who is seeking to be deemed an employee of the Sponsor in order to claim Workers' Compensation benefits from the Named Insured within the applicable Workers' Compensation law. This Coverage Part, including any riders, endorsements, and amendments constitute the Coverage granted. The Insurer and you, the Named Insured Sponsor, have agreed to all the terms contained therein.

Read the entire Coverage Part Coverage carefully to determine rights, duties and what is and is not covered.

Section 1 – Definitions

Definitions

Accident, in this Coverage Part, means an event which:

- was unforeseen, unplanned and unexpected;
- occurred at a specifically identifiable time and place;
- occurred by sudden and abrupt cause or by chance;
- resulted in physical injury to a Subscriber;
- arose out of and in the course of a Subscriber's duties under a Covered Contract; and
- occurred during the Coverage Period.

Bodily Injury means an occupational accident resulting in physical Injury to a Subscriber which occurs during the coverage period and while the Subscriber is under contract and arises solely out of and in the course of their occupation and duties as defined in the covered contract.

Covered Contract means a legal, written work or lease agreement that meets state independent contractor requirements and definitions as further defined in the Covered Activity Rider and has been submitted to and approved by the Insurer.

Subscriber means Your owner/operators and contract drivers; provided:

- they have a written Covered Contract with You;
- they are covered under an occupational accident Coverage approved by TOA and the Insurer;
- their name is on file with the Insurer or the Insurer's administrator; and
- they are not (prior to a claim under this Coverage) a statutory employee of yours or another Subscriber.

Legal Expenses means expenses incurred in defending You against claims, proceedings and suits and amounts incurred as:

- premiums for bonds to release attachments and for appeal bonds;
- litigation costs included in a judgment against You; and
- interest on judgments as required by law until the Insurer offers the amount due under this insurance.

Occurrence means an Accident or series of Accidents arising out of one event or incident.

State means any State of the United States of America and the District of Columbia.

Worker's Compensation Law(s) means the worker's compensation law of each State. lt includes any

amendments to that law which are in effect during the Coverage Period. lt does not include nonoccupational disability benefits.

You or **Your** refer to the Named Insured Sponsor shown in the Certificate issued by TOA.

Section 2 – General Section

General Section

A. Coverage
This Coverage íncludes, at its effective date, the provisions of this Coverage as stated in the Policy and these Terms & Conditions, the Schedule and all endorsements and schedules listed. lt is a contract of insurance between You and the Insurer. The only agreements relating to this insurance are stated in this Coverage. The terms of this Coverage may not be changed or waived except by rider or endorsement issued by the Insurer to be part of this Coverage.

B. The Coverage Period
The Coverage Period is shown in the Certificate issued by TOA. lf this Coverage is cancelled, the Coverage Period will end at 12:01 A.M. on the cancellation date.

C. Who Is Insured
ln addition to the Named Insured Sponsor in the Certificate issued by TOA, each of the following is also a Named Insured:

1. lf the Named Insured in the Certificate is an individual, then his spouse, but only with respect to the conduct of a business of which the Named Insured is the sole owner.
2. lf the Named Insured in the Certificate is a partnership or joint venture, then the partners and their spouses or members of the joint venture but only with respect to the conduct of the partnership's or joínt venture's business.
3. lf the Named Insured in the Certificate is a corporation, then the directors, officers and stockholders of the corporation, but only with respect to the conduct of the corporation's business.

Section 3 – Insuring Agreements

Insuring Agreements

Coverage - Contract Liability

The Insurer will reimburse You for the benefit You are required to pay under the Workers' Compensation laws of any State because of an Accident resulting in Bodily Injury to a Subscriber; provided that:

- It is determined by a court of law or the appropriate State regulatory authority that You are required to pay those benefits within 36 months after the date of the Accident; and

- the Accident must take place during the Coverage Period shown in the Certificate.

The Insurer will defend any claim, proceeding or suit against You for claims payable under this Coverage. The Insurer has the right to investigate and settle these claims, proceedings or suits. The Insurer has no duty to defend or continue defending a claim, proceeding or suit after the Insurer has paid its applicable Limit of Liability under this Coverage.

The Insurer will pay on Your behalf the benefits required of You by the Workers' Compensation Law of any State up to the Limits of liability shown in Item 8 of the Schedule.

lf the Insurer makes any payments ín excess of the benefits regularly provided by the Workers Compensation Law of any State on Your behalf, You will reimburse the Insurer promptly.

Section 4 – Limit of Liability

Limit of Liability

The Limits of Liability shown on Item 8. of the Schedule is the most the Insurer will pay.

The Limits of Liability shown in Item 8. of the Schedule is the most the Insurer will pay for all claims involving Bodily Injury covered under this Coverage to any one Subscriber.

Naming more than one Named Insured in the Certificate does not increase the Insurer's Limit of Liability under this Coverage.

Section 5 – Exclusions

Exclusions

This Coverage does not apply to:

1. Claims which did not arise from or in connection with an Accident while under dispatch.

2. Claims arising out of the promulgation of any statute, regulation, or rule, or the amendment of any existing statute, regulation, or rule, the effect of which is to make an Owner-Operator or Contract Driver Your employee for purposes of the Workers' Compensation law.

3. Claims arising out of all causes of action other than the Workers' Compensation laws.

4. Claims for an intentionally self-inflicted Bodily Injury to a Subscriber while either sane or insane or Bodily Injury intentionally caused or intentionally caused or intentionally aggravated by You.

5. Claims resulting from a Subscriber's participation in:
    a. a riot or act of civil disturbance;
    b. a felony;
    c. a war, declared or undeclared;
    d. any act of war; or
    e. the service of the armed forces of any country or any civilian non-combatant unit serving with such forces.

6. Claims for Bodily Injury if the Subscriber was legally intoxicated under the law of the State where the Accident occurred.

7. Claims resulting from nuclear reaction, nuclear radiation or radioactive contamination.

8. Claims for Bodily Injury occurring while the Subscriber was under the influence of any chemical substance not lawfully available or consumed in accordance with the Controlled Substance Act in force at the time and location of the Accident.

9. Claims for Bodily Injury occurring outside the United States of America, its territories or possessions and Canada.

10. Claims brought by a símilarly situated Subscriber after the issuance of an order by a state administrative or regulatory agency or board or a court of competent jurisdiction which has the effect of making all of Your similarly situated Subscribers employees for the purposes of workers' compensation insurance.

11. Claims arising from Employers' Liability.

Section 6 – Claims

Claims

1. Duty to Defend

The Insurer will defend You against any claim, proceeding or suit against You for Bodily Injury covered by this insurance. The Insurer has the right to investigate and settle any claim, proceeding or suit at the Insurer's discretion. The Insurer has a duty to defend a claim if You are not defended by a Workers' Compensation insurer. The Insurer has no duty to defend or continue defending after the Insurer has paid its applicable Limit of Liability shown in Item 8. of the Schedule. You shall cooperate fully with the Insurer and TOA and assist the Insurer and TOA in the investigation, settlement or defense of any claim, proceeding or suit and shall, upon the Insurer's or TOA's request, supply:

a. the names and addresses of the injured Subscriber(s) and any witness(es);
b. all notices, demands and legal papers related to a Bodily Injury covered under this

insurance; and

c. such other information as the Insurer and TOA may require.

2. Claim Reporting

You shall notify the Insurer as soon as practicable in the event of a claim or a situation which may result in a claim. Such notice shall be sent to:

Gallagher Bassett
P.O. Box 4L9797,
Kansas City,
MO 64141, USA

Attn: Brenda Cullinan
Tel: 816 216 5200
Email: Brenda cullinan@gbtpa.com

You agree not to voluntarily make payments, assume obligations or incur expense on any claim, proceeding or suit against You for Bodily Injury that may be covered by this insurance except at your own cost.

3. Subrogation - Recover From Others

The Insurer has Your rights to recover any payments. The Insurer may make recoveries under this insurance from anyone liable for Bodily Injury covered by this insurance. You will do everything necessary to protect those rights for the Insurer and help the Insurer enforce them. You agree to do nothing that would interfere with those rights after any Bodily Injury.

4. Sunset Clause

This Coverage applies in respect of incidents which occur during the Coverage Period stated in the Certificate provided that, and only in so far as, such incidents are reported to the Insurer and TOA within thirty six (36) months of the end of the Coverage Period stated in the Certificate unless extended by a longer period due to the filing of a compensable claim under a State's Worker's Compensation law, which claim is not barred by a statute of limitations or similar statute under state's Workers' Compensation law.

5. Commutation

The Insurer has the right to commute all claims at any point after sixty (60) months from the end of the Coverage Period. All claims which are not finally settled will be eligible for commutation. An Independent actuary or appraiser shall be appointed by mutual agreement between You and the Insurer. The independent actuary or appraiser shall investigate, determine and capitalize the present value of such unsettled claims. The Insurer will share the expenses of the independent actuary or appraiser with You equally. The Insurer will advise You in writing of the Insurer's intention to commute along with the name of the Insurer's chosen appraiser and if You fail to respond in writing within 90 days then You will be deemed to have consented to the same.

lf the Insurer and You cannot them mutually agree to an independent actuary or appraíser, both the Insurer and You will appoint their own independent actuary or appraiser who will, in turn, appoint a third independent actuary or appraiser who will establish the present value of each claim(s). The Insurer and You will pay the expenses of their own independent actuary or appraiser and share the expenses of the third independent actuary or appraiser equally.

The Insurer will pay You the present value determined by the independent actuary or appraiser within 30 days from receipt of the independent actuary's or appraiser's report. Upon receipt of the Insurer's payment, You agree to release the Insurer from any further liability under this Coverage for such claim(s). lf for any reason, the Insurer fails to make payment within thirty (30) days of receipt from the independent actuary or appraiser, then the Insurer will pay You interest at the rate of 5% per annum on the present value of such claim(s) from the date payment was due to the date of actual payment.

Section 7 – Conditions

1. Agreement Upon Terms
Your acceptance of this Coverage means that You agree with the Insurer and TOA that the statements You provided to TOA and the Insurer are Your representations, that this Coverage is issued in reliance upon such representations, and this Coverage as stated in the Policy and these Terms & Conditions embodies all agreements between You and the Insurer, or any of the Insurer's agents, relating to this insurance, and that Your full compliance with all terms of this Coverage is a condition to the Insurer's liability hereunder.

2. Assignment
Your rights or duties under this Coverage may not be assigned or transferred without the Insurer's written consent.

3. Other Insurance
lf any other insurance, indemnity or reimbursement agreement exists protecting You for Bodily Injury to which this insurance applies, this insurance shall be excess of such other insurance, indemnity or reimbursement agreement. But this does not apply to any excess insurance, indemnity or reimbursement agreement specifically purchased by You to apply in excess of our Limit of Liability.

4. Several Liability Notice
The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

COMMON CONDITIONS

(applicable to Occupational Accident and Contingent Liability benefits)

A. Sponsor's and Subscriber's Additional Obligations. TOA and/or the Insurer have no duty to provide any benefit or payment, and may also cancel coverage, unless there has been full compliance with the following duties:

- It is the Sponsor's duty and Subscriber's duty to fully comply with all of the provisions of the Contract, the Certificate, these Terms & Conditions or those of the Policy.
- It is the Sponsor's duty and Subscriber's duty to deliver proper documentation in a timely manner as required by TOA, the Insurer, their designees, the Certificate, these Terms & Conditions or those of the Policy.
- It is the Sponsor's duty to inform any Subscribers/beneficiaries that you sponsored about any suspension or cancellation of benefits or coverage, and any change in Terms & Conditions and Policy provisions.
- TOA will deliver TOA's correspondence with TOA members and TOA Program participants to the Sponsor's address or email or fax. It is the Sponsor's duty to deliver that correspondence to all persons it sponsored for TOA membership and the TOA Programs.

B. Coverage Is Subject To Underlying Policy's Terms, Provisions, Limitations, Exclusions, Conditions And Definitions. The coverage provided by TOA's Occupational Accident Benefits and Optional Contingent Liability Benefits-Package Program is subject to all of the underlying Policy's terms, provisions, limits, exclusions, conditions and definitions. If there is no coverage under the Insurer's policy, then there is no eligibility for any TOA Program benefit that is related to that policy.

C Inspection. The Insurer has the right, but not the duty, to inspect Your or a Subscriber's operations and work places. Such inspections are not safety inspections. They relate only to the insurability of the work places and the premiums to be charged. The Insurer may give reports to You or a Subscriber on the conditions found upon inspection. The Insurer does not undertake to provide for the health or safety of Your or a Subscriber's employees, Independent Contractors or the public. The Insurer does not warrant that Your or a Subscriber's work places are safe or healthful or that they comply with any law, regulation, code or standard.

D. Audit. You agree to keep records of information needed to compute premium. You agree to let the Insurer or its representative examine and audit all payroll, business records, and documents including ledgers, journals, registers, vouchers, contracts, dispatch logs, tax reports, disbursement records and programs for storage or retrieving data. The Insurer has the right to conduct audits during regular business hours while the Certificate and coverage is in force and within three (3) years after the final settlement of all claims under the Certificate and coverage.

E. Bankruptcy or Insolvency. Your or a Subscriber's bankruptcy, insolvency or other financial deficiencies will not relieve the Insurer from liability under the Certificate and coverage. However, the

Insurer's reimbursement obligations and/or liability will be the same as they would have been had your bankruptcy, insolvency or other financial deficiencies not occurred.

F. Actions of Law and Limitation Period.

Since only the Insurer can approve or deny the payment Occupational Accident and Contingent Liability benefits, any legal action for payment of such benefits or to recover under the Certificate must be brought against the Insurer, and may not be brought against TOA.

Furthermore: (1) no one may bring a legal action against TOA for any reason pertaining to this Contract and Program until there has been full compliance with the Contract provisions and these Terms and Conditions and all of the terms of the Policy; and (2) no legal action can be brought against TOA unless the action is started within 12 months after the event or occurrence which gave rise to the action.

With respect to Occupational Accident benefits, no legal action may be brought against the Insurer to recover under the Certificate prior to sixty (60) days after filing proof of loss. No such action may be brought against the Insurer after three (3) years from the time written proof of loss is required to be given.

G. Conformity with State Statutes. If any provision of this Contract, the *Certificate*, these Terms & Conditions or the Policy is in conflict with the statutes of the State in which the *Certificate* is delivered or issued for delivery, the provision is automatically amended to meet minimum requirements of the statute.

H. Severability. If any provision of this Contract, the *Certificate*, these Terms & Conditions or the Policy is found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability will not affect the other provisions which will remain in full force and effect.

ACCEPTANCE AND ELECTRONIC DELIVERY

By clicking "I Agree":

You acknowledge that you have reviewed the Terms & Conditions, understand them and agree to them.

You acknowledge that you know you can print a paper copy of the Terms & Conditions, review them at your leisure, and cancel the Contract at any time if you decide you no longer like the Terms & Conditions.

You acknowledge that the Terms & Conditions will be a part of and govern our Contract.

You certify that you are duly authorized to bind the company or business indicated in the Application.

You consent to conduct all transactions with TOA and our agents by electronic means, which consent you may withdraw by notifying us via email.

You are asking us to electronically deliver documents, and are foregoing your option to receive paper documents by regular mail.

You confirm that you are able to open, view, save and print PDF documents, that you have provided your email address, and that you can receive paperless documents through email, our website and PDF.

You agree that you will notify us if your email address changes.

Cancel **I Agree**