

UNITED STATES FIRE INSURANCE COMPANY

Home Office: 2711 Centerville Road, Suite 400, Wilmington, DE 19808

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER: InsuraGuest Risk Purchasing Group, LLC – Sports & Events Activities Program

POLICY NUMBER: US1860837

POLICY EFFECTIVE DATE: September 20, 2022

POLICY EXPIRATION DATE: July 20, 2023

This Policy is issued in the state of **UTAH** and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

30 DAY RIGHT TO RETURN THIS POLICY

If for any reason, you are not satisfied with this Policy, you may return it to us within 30 days after receiving it. Upon its return, we will refund any premium paid and this Policy will be deemed void, just as though it had never been issued.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

NOTICE TO BUYER: THIS IS ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. REVIEW YOUR POLICY CAREFULLY

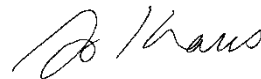
THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS POLICY IS NOT RENEWABLE.

Signed for **United States Fire Insurance Company** By:



Marc J. Adey
Chairman and CEO



James Kraus
Secretary

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SCHEDULE OF BENEFITS

BENEFIT PERIOD: 13 weeks from the date of the Covered Injury, provided the Expense occurs prior to the Expiration Date and care is Medically Necessary and while the Policy is in force.

CLASS OF ELIGIBLE PERSONS: Class 1: All ticketed participants who participate in a Covered Activity and for whom premium has been paid.

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum:	N/A
AD&D Aggregate Limit Amount:	N/A
Time Period for Loss:	365 days from the date of the Accident

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum Amount per occurrence per Covered Person: \$10,000 – Mandatory Plan
\$25,000 – Voluntary Plan

Policy Deductible: \$0

The Deductible must be satisfied before this plan will pay benefits. Amounts paid by other carriers will be used to satisfy the deductible under this plan. With a Deductible, any amounts paid by other Valid and Collectible Insurance towards the satisfaction of bills generated as a result of a covered Accident will count towards satisfying the deductible.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	100% of the Semi-Private Room Rate
Intensive Care/Cardiac Care Room & Board:	100% of URC
Hospital Miscellaneous Benefit:	100% of URC
Pre-Admission Testing Benefit:	100% of URC

BSR-2020-UT

In-Patient Surgical Benefits:

Primary Surgeons Maximum Benefit Amount: 100% of URC
Assistant Surgeon Benefit: 100% of URC

Out-Patient Surgery Benefits:

Outpatient Primary Surgeons Maximum Benefit Amount: 100% of URC
Outpatient Assistant Surgeon Maximum Benefit: 100% of URC
Outpatient Surgical Facility Maximum Benefit: 100% of URC

Emergency Room Benefit 100% of URC

Anesthesia Benefit: 100% of URC

Physician's Visits

In-Hospital Maximum Benefit: 100% of URC

Physician's Visits

Office Visits (Out-of-Hospital) Maximum Benefit: 100% of URC

X-Ray Benefit 100% of URC

Laboratory Benefit 100% of URC

Nursing Benefit Amount: 100% of URC

Outpatient Physiotherapy Benefit 100% of URC

Ground Ambulance Benefit Amount: 100% of URC

Dental Treatment For Injury Only Benefit Amount: 100% of URC

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Accident means a sudden, unforeseeable event which:

1. Causes Injury to one or more Covered Persons; and
2. Occurs while coverage is in effect for the Covered Person.

AD&D Aggregate Limit means the maximum amount We will pay for all Covered AD&D claims during a policy period. WE will NOT be liable for any amount over such limit for any one Accident. If the total amount of benefits to be paid under this Policy is more than the AD&D Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

Aircraft means a vehicle which:

1. Has a valid certificate of airworthiness; and
2. Is being flown by a pilot with a valid license appropriate to the aircraft.

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual, Reasonable and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and which is performed or given under the direction of a Physician for treatment of an Injury. Coverage under the Policy must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for a an Injury cannot be in excess of the maximum benefit amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Person means a member of the Class of Eligible Persons identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Policy.

Deductible means the dollar amount of all Covered Expenses that must be incurred before policy benefits are eligible under the Blanket Policy. The Deductible may be satisfied by Other Valid and Collectible Insurance or Health Care Plan. The Deductible is shown on the Schedule of Benefits.

Dependent means the Insured's unmarried child who:

1. Is within the following age groups (unless otherwise shown in the Application):
 - a. Under 26 years of age;
 - b. 26 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, a child for whom a court order applies, and natural child.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Policy is in force.

He, his, and him includes she, her and hers.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or
7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Hospital means an institution which is duly licensed and operating within the scope of its license.

Hospital does not include:

1. A clinic or facility for:
 - a. Convalescent, custodial, educational or nursing care;
 - b. The aged, drug addicts or alcoholics;
2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
 - a. The services are rendered on an emergency basis; and
 - b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Immediate Family Member means the Covered Person's parent (includes step-parent), grandparent, Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

Medically Necessary or Medical Necessity means

- a. health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
 - i. in accordance with generally accepted standards of medical practice in the United States;
 - ii. (ii) clinically appropriate in terms of type, frequency, extent, site, and duration;
 - iii. (iii) not primarily for the convenience of the patient, physician, or other health care provider; and
 - iv. (iv) covered under the contract;
- b. when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.
 - i. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.
 - ii. For established interventions, the effectiveness shall be based on:
 - (A) scientific evidence;
 - (B) professional standards; and
 - (C) expert opinion.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether Insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Any amount payable for Hospital, medical or other health services for Accidental bodily Injury arising out of a motor vehicle Accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement.
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he or she becomes disabled while Insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Physician means a person who is a qualified practitioner of medicine. A such, He or She must be acting within the scope of his/her license and under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate.

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

Spouse means the lawful Spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

Supervised or Sponsored Activity means a Policyholder or School authorized function:

1. In which the Covered Person participates;
2. Which is organized by or under its auspices;
which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

Usual, Reasonable and Customary means:

(a) the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

ELIGIBILITY FOR INSURANCE

Eligibility:

Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits or Application. This includes anyone who may become eligible while this Policy is in force.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date: The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date: A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:

1. The Effective Date of the Policy; or
2. The day He becomes eligible, according to the referenced date shown in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

1. The Policy Termination Date shown in the Policy; or
2. The last day of the grace period if premiums are not paid.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the grace period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

The Policyholder shall notify the Covered Persons that coverage is being terminated and that He does not have the right to continue coverage upon that termination.

Termination:

Insurance for a Covered Person will end on the earliest of:

1. The date he is no longer in an Eligible Class.
2. The date he reports for active duty in any Armed Forces. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a. The date the premium is fully earned; or
 - b. The Expiration Date of this Policy.This does not include Reserve or National Guard duty for training;
3. The end of the grace period for which the last premium contribution is made; or
4. The date this Policy is terminated.

Covered Person's Termination Date

Insurance for a Covered Person will end on the earliest of:

1. The date He is no longer in an Eligible Class.
2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a. The date the premium is fully earned; or
 - b. The Expiration Date of this Policy.
This does not include Reserve or National Guard duty for training;
3. The end of the grace period for which the last premium contribution is made; or
4. The date this Policy is terminated; or
5. The date the Covered Person requests, in writing, that his/her coverage be terminated.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which:

1. Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under this Policy; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Primary Medical Expense:

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, we will pay the applicable benefit, subject to the Deductible Amount (if any).

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for treatment of a covered Injury:

1. While the person is insured under this Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF HAZARDS

HAZARD: EXPOSURE TO THE ELEMENTS OR DISAPPEARANCE

Subject to all other terms and conditions of this Policy, we will:

1. Pay the applicable benefit for a Covered Person's loss specified therein, which results from exposure to the elements or disappearance due to:
 - a. The forced landing; stranding; sinking; or wrecking of a vehicle in which a Covered Person was traveling; and
 - b. Such incident occurs from an Accident for which this Policy provides coverage under the Description of Hazards; or
2. Presume that a Covered Person has died if:
 - a. A vehicle in which he is traveling disappears; sinks; is stranded; or is wrecked; as a result of an Accident for which this Policy provides coverage under the Description of Hazards; and
 - b. His body is not found.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

HAZARD: SPECIFIC ACTIVITY

We will pay the benefits described in this Policy, for a covered loss by a Covered Person while participating in scheduled, sponsored and supervised activities on premises of the Member Resort property. Coverage includes the following activities: skiing, snow tubing, ice skating, snowboarding, scenic chairlift rides, bike park visits, golf, tennis, mountain coaster, mountain park visits, white water course, tubing, wall climbing, gem mining and lake activities.

Benefits will not be payable for activities that include competitive skiing, aerial jumping, acrobatic ski activities, any exposure in direct violation of hazards such as closed trails, snowmobiling/ATV and other off road motored contrivances, archery, bungee jumping, zip lining, zip tours and bouncy houses.

DESCRIPTION OF BENEFITS

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Benefit Periods, benefit maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 90 days after the date of the Covered Accident.

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

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses:** charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

2. **Intensive Care/Cardiac Care Room and Board** - charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.
3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.
4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing).
5. **In-Patient Surgical Benefits** - charges for:
 - a. A Physician, for primary performance of a surgical procedure, up to the maximum benefit amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
 - b. A Physician, for: assistant surgeon duties up to the maximum benefit shown in the Schedule of Benefits for an Assistant Surgeon.
6. **Out-Patient Surgery Benefits:**
 We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:
 - a. necessary for treatment of the Covered Person; and
 - b. given in the outpatient department of a Hospital or an ambulatory surgical center.
7. **Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

 Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.
8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:
- a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.
 - b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.
- Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.
10. **X-Ray Benefit** - We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x-ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.
11. **Laboratory Benefit**- We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.
12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.
13. **Physiotherapy** - Charges for physiotherapy:
- a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.
- Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.
- Total treatment per Injury will not exceed the maximum benefit amounts for Physiotherapy shown in the Schedule of Benefits.
14. **Ground Ambulance** - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.
- Ground Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the injured from the scene of the Accident to a Hospital. Surface trips must be to the closest local facility that can provided the covered service appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area.
15. **Dental Treatment for Injury Only** - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the maximum benefit amount shown in the Schedule of Benefits for the Dental Treatment benefit.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Voluntary participation in a riot or insurrection.
6. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental bodily injury or accidental food poisoning.
7. Disease or disorder of the body or mind.
8. Mental or nervous disorders.
9. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
10. Intoxication or being under the influence of any drug or narcotic. Intoxicated will have the same meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
11. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol (if over the legal limit, determined by the laws in the jurisdiction of the geographical area where the loss occurs), illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
12. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
13. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
14. Intentional violation or attempt to violate any duly-enacted law or regulation, or voluntary commission or attempt to commit an assault or felony, or that occurs while voluntarily engaged in an illegal occupation. The loss incurred must directly result from the Covered Person's voluntary participation.
15. Conditions that are not caused by a Covered Accident.
16. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
17. Any treatment, service or supply not specifically covered by this Policy.
18. Loss resulting from participation in any activity not specifically covered by this Policy.
19. Charges which Are in excess of Usual, Reasonable and Customary charges.
20. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
21. Regular health check ups.
22. Services or treatment rendered by an Immediate Family member of the Covered Person;
23. Injuries paid under Workers' Compensation, Employers liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
24. That part of the medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited).
25. Participation in any motorized race or speed contest.
26. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is a Covered Accident.
27. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.

28. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in this Policy.
29. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident..
30. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
31. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
32. Travel in or upon:
 - a. A snowmobile;
 - b. A water jet ski;
 - c. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
 - d. Any off-road motorized vehicle not requiring licensing as a motor vehicle.
33. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b. While being used for any test or experimental purpose; or
 - c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
 - d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
 - e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f. an ultralight hang-gliding, parachuting, or bungee-cord jumping;
Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business purposes.
34. Treatment for an Injury that is caused by or results from a nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
 - a. The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy and
 - b. The Covered Person was within a 25-mile radius of the site of release either:
 - i. At the time of the release; or
 - ii. Within 24 hours of the start of the release
35. The repair or replacement of existing artificial limbs, orthopedic braces or orthotic devises.
36. Rest cures or custodial care.
37. Prescription medicines unless specifically provided for under this Policy.
38. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

PREMIUM PROVISIONS

GRACE PERIOD:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:

Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the grace period.

CHANGES IN RATES:

We have the right to change the premium rates on any premium due date:

1. After the first 12 months insurance is in effect;
2. Coinciding with a change in the coverage provided or classes eligible; or
3. Coinciding with a change in the risks we have assumed.

We will give 45 days written notice of any change under 1. Above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under this Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under this Policy. Examination may occur at any reasonable time up to the later of:

1. The two year period after the expiration of the Policyholder's coverage; or
2. The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

1. The names of all persons insured on the Effective Date of this Policy;
2. The names of all persons who are insured after the Effective Date of this Policy;
3. The names of those persons whose insurance has terminated; and
4. Additional information required as agreed to by us and the Policyholder.

NEWLY ACQUIRED SUBSIDIARIES:

The premium for this Policy applies to the risks assumed on the Effective Date of this Policy. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under this Policy, subject to the following conditions:

1. The Policyholder has at least 50% controlling interest in the subsidiary.
2. An additional premium payment is required with a report to us and the name of any newly acquired subsidiary.
3. Necessary underwriting information must be furnished for us to determine the additional risks assumed.
4. Coverage will begin on the legal date of acquisition.

No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.

POLICY TERMINATION:

We may terminate coverage on or after any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such termination. The Policy will automatically terminate at the end of the Grace Period if the Policyholder does not pay the premium due prior to the end of the Grace Period.

The Policyholder must provide written notice of termination to each group member prior to termination.

CONFORMITY WITH STATE STATUTES:

Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

INCONTESTABILITY:

A statement made by an applicant relating to the person's insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years. The Company has the burden of proving fraud by clear and convincing evidence.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice must be given to us within 20 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:

When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

Failure to furnish such proof within the time period shall not reduce any claim if it was not reasonably possible to furnish such proof within such time period, provided such proof is furnished as soon as reasonably possible. Failure to file Proof of Loss as required does not bar recovery under the policy if we fail to show we were prejudiced by the failure.

TIME OF PAYMENT OF CLAIMS:

Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:

Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:

All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)

The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:

If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:

1. The Covered Person first agrees in writing to refund the lesser of:
 - a. The amount we actually paid for such expenses; or
 - b. The amount actually received from the third party for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

PHYSICAL EXAMINATION AND AUTOPSY:

We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:

1. Received in a covered Accident; and
2. Which are covered under:
 - a. workers' compensation or similar statutory remedies available under law; or
 - b. Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

SUBROGATION:

If we have paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

LEGAL ACTIONS:

No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. A Covered Person who disagrees with the results of an internal review may submit the Adverse Benefit Determination for an Independent Review if the Adverse Benefit Determination involves payment of claim regarding Medically Necessary treatment or denial of a claim regarding Medically Necessary treatment. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A "**Grievance**" is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

"**Adverse Benefit Determination**" means the:

- a) denial of a benefit;
- b) reduction of a benefit;
- c) termination of a benefit; or
- d) failure to provide or make payment, in whole or in part, for a benefit.

"**Adverse Benefit Determination**" includes:

- a) denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's or a Dependent's eligibility to participate in a Health Care Plan;
- b) denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of a utilization review; and
- c) failure to cover an item or service for which benefits are otherwise provided because it is determined to be: (a) experimental/investigational treatment; or (b) not Medically Necessary treatment or appropriate.

"**Independent Review**" means a process that:

- a) is a voluntary option for the resolution of an Adverse Benefit Determination;
- b) is conducted at the discretion of the Covered Person;
- c) is conducted by an independent review organization designated by Us;
- d) renders an independent and impartial decision on an Adverse Benefit Determination submitted by a Covered Person; and
- e) may not require the Covered Person to pay a fee for requesting the Independent Review.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60 days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30 days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20 days after receiving the Grievance. The written decision must include:

- (1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
- (2) A statement of the reviewer's understanding of the Grievance.
- (3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
- (4) A reference to the evidence or documentation used as the basis for the decision.
- (5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
- (6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First Level Review for an Adverse Determination. Within 10 business days after receiving a request for a Second Level Review, we will advise you of the following:

- (1) The name, address, and telephone number of a person designated to coordinate the Grievance Review for the Company.
- (2) A statement of your rights, including the right to:
 - Attend the Second Level Review.
 - Present his/her case to the review panel.
 - Submit supporting materials before and at the review meeting.
 - Ask questions of any member of the review panel.
 - Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
 - Request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45 days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15 days prior to the date. The review meeting will be held during regular business hours at a location reasonably accessible to you. In cases where a face-to-face meeting

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is not practical for geographical reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own. The panel must be comprised of persons who:

- (1) Were not previously involved in any matter giving rise to the Second Level Review;
- (2) Are not employees of the Company or Utilization Review Organization; and
- (3) Do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

- (1) The name(s), title(s) and qualifying credentials of the members of the review panel.
- (2) A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts.
- (3) The review panel's recommendation to the Company and the rationale behind the recommendation.
- (4) A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation.
- (5) In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination.
- (6) The rationale for the Company's decision if it differs from the review panel's recommendation.
- (7) A statement that the decision is the Company's final determination in the matter.
- (8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the time frames for an Informal, formal First Level Review or Second Level Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24 hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72 hours after the review has commenced. Written communication of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level Reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

Grievance

PRIVACY NOTICE

United States Fire Insurance Company, The North River Insurance Company and affiliates within Crum & Forster (collectively, "The Company") values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information including nonpublic personal information about our customers and claimants. Nonpublic personal information means information that allows someone to identify or contact you ("Information"). We are committed to protecting such Information and we will comply with all applicable federal and state laws and regulations. This notice describes how we collect, use and share your Information, your rights with respect to insurance products issued by The Company and our legal duties and privacy practices. State laws require that we provide this notice. Please review this Notice and keep a copy of it with your records.

Your privacy is our concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. The Company limits the collection, use, and disclosure of such information to only what is needed to properly produce, underwrite and service its insurance products and/or fulfill legal or regulatory requirements. The Company maintains administrative, technical and physical safeguards that comply with state and federal regulations to protect your Information. We also limit employee access to Information to those with a business reason for knowing such Information and we take measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our Information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical providers, insurance support organizations, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

The Company collects nonpublic information to conduct its business of producing, underwriting, servicing and administering its insurance products. If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

Access to non-public personal information is limited to those employees, and authorized representatives, attorneys and service providers who specifically need such information to conduct their business responsibilities. In addition, we may disclose all the information that we collect about you to affiliated companies and nonaffiliated third parties (as permitted by law), such as:

- Insurance companies;
- Insurance agencies;
- Loss adjusters;
- Medical providers;
- Third party non-insurance service providers;
- Third party administrators;
- Medical bill review companies;
- Reinsurance companies; and
- Similar service providers.

Crum & Forster requires its service providers to abide by privacy laws in handling non-public personal information obtained through its business relationship with Crum & Forster. Additionally, Crum & Forster may disclose non-public personal information to third parties as allowed or required by law. For example, Crum & Forster may release your Information to comply with reporting requirements, to comply with a subpoena, warrant, legal process or other order or inquiry of a court, governmental agency or state or federal regulator, or to fulfill C&F's obligations to its insurers and reinsurers. We may also share your personal information in order to establish or exercise our rights, to defend against a legal claim, to investigate, prevent, or take action regarding possible illegal activities, suspected fraud, safety of person or property, or a violation of our policies.

If you conclude your relationship with the Company, the Company will continue to safeguard your privacy in accordance with the standards described in this notice. The Company maintains physical, electronic and procedural safeguards to protect non-public personal information.

About Our Websites

We may collect information via technology about how you use our website, including the elements you have interacted with, metadata, and other details about these elements, clicks, change states, and other user actions. This information is used primarily to provide, maintain, protect, and improve our current products and to develop new ones.

We may use cookies on certain pages of our site. Cookies are stored on your computer, not on our site. Most cookies are "session cookies" which means that they are automatically deleted at the end of each session. A cookie itself does not have the ability to automatically collect personal information about you. A cookie can store certain information that identifies your computer to us so that you do not need to re-enter that information as frequently when you use our site. The cookie does not contain your password.

We reserve the right to change our policy regarding cookies and the collection of information from visitors at any time without advance notice. Should any new policy be put into effect, we will post it on this website, and the new policy will apply only to information collected thereafter. You may opt out of receiving cookies or delete any prior cookies by changing your specific internet browser settings. The privacy of communication over the internet cannot be guaranteed. If you are concerned about the security of your communication, we encourage you to send your correspondence through the postal service or use the telephone to speak directly to us. We do not represent or warrant that the site, in whole or in part, is appropriate or available for use in any particular jurisdiction. Those who choose to access the site, do so on their own initiative and at their own risk, and are responsible for complying with all local laws, rules and regulations. We do not assume any responsibility for any loss or damage you may experience or incur by the sending of personal information over the internet by or to us. This Usage Agreement shall be governed by the laws of the United States and of the State of New Jersey, without giving effect to its conflict of laws provisions.

Please know that The Company has not and will not sell any consumers' personal information. We do not sell your nonpublic personal information to any third parties nor do we use it for marketing purposes.

How to contact us

If you have any questions about this Privacy Notice or about how we use the information we collect, please contact us at:

Crum & Forster Legal Department
305 Madison Avenue
Morristown, NJ 07960
privacyinformation@cfins.com

Changes to this Privacy Notice

We may revise this notice at any time. If we make material changes, we will notify you as required by law.

For California Residents Only:

If you are a California resident, you may be entitled to additional rights over your Information. We do not, and will not, sell Information collected from you. The California Consumer Privacy Act (CCPA) provides California residents, upon a verifiable consumer request, certain rights that include:

The right to request that we disclose (1) The categories of personal information that we have collected about you; and (2) The categories of personal information that we have disclosed about you for a business purpose

The right to request that we delete the personal information it has collected from you, subject to certain legal exceptions, for example, when such personal information is necessary to fulfill or comply with our legal obligations.

The right to be protected from discrimination for exercising your CCPA rights. If you choose to exercise your privacy rights, we will not charge you different prices or provide different quality of services unless those differences are related to your information.

You may designate an authorized agent to act on your behalf and make a request of us under the CCPA.

To exercise your rights under the CCPA or to seek assistance, please do one of the following:

- If you would like to make a Request to Know, go to <http://www.cfins.com/request-to-know-california-residents/> or call 1.844.254.5754
- If you would like to make a Request to Delete, <http://www.cfins.com/request-to-delete-california-residents/> or call 1.844.254.5754
- Fill out and send back to us the Request to Know / Request to Delete form to:
Crum & Forster Legal Department
PO Box 1973
305 Madison Avenue
Morristown, NJ 07962
privacyinformation@cfins.com

We will attempt, where practical, to respond to your requests and to provide you with additional privacy-related information. We will confirm receipt of verifiable consumer requests within ten (10) days of receipt. You may only make a verifiable consumer request for personal information twice within a twelve (12) month period. We cannot respond to your request if we cannot verify your identity or authority to make the request and confirm the personal information relates to you. Any consumer with a disability may access this notice by contacting us at the address, email or toll free number listed above.

We may change this California Privacy Notice and our privacy practices over time. Our most current Privacy Policy and California Privacy Notice can be found on our website at <http://www.cfins.com/terms/>.

January 2020