

## Certificate of Insurance

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ZURICH AMERICAN INSURANCE COMPANY  
Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 3809952 to cover the eligible individuals of:

**The Office of Employee Benefits of the Federal Reserve System  
(hereafter to be referred to as The Federal Reserve System)**

**Covered Subsidiaries or Affiliated Companies:**

**Federal Reserve Bank of Boston  
Federal Reserve Bank of New York  
Federal Reserve Bank of Philadelphia  
Federal Reserve Bank of Cleveland  
Federal Reserve Bank of Richmond  
Federal Reserve Bank of Atlanta  
Federal Reserve Bank of Chicago  
Federal Reserve Bank of St. Louis  
Federal Reserve Bank of Minneapolis  
Federal Reserve Bank of Kansas City  
Federal Reserve Bank of Dallas  
Federal Reserve Bank of San Francisco  
Board of Governors of the Federal Reserve System (Board)  
Office of Employee Benefits of the Federal Reserve System (OEB)  
Federal Reserve Information Technology (FRIT)**

The insurance evidenced by this **Certificate** provides **ACCIDENT** insurance only. It does not provide **Coverage** for sickness. This **Certificate** describes the main features of the **Policy**, but the **Policy** is the only contract under which benefit payments are made. If there is an inconsistency between the **Certificate** and the **Policy**, the **Policy** will govern.

### **IMPORTANT NOTICE**

**THIS INSURANCE PROVIDES ACCIDENT COVERAGE ONLY  
THIS INSURANCE DOES NOT PROVIDE BENEFITS FOR SICKNESS**

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## SECTION I – ELIGIBILITY AND EFFECTIVE DATES

### CERTIFICATEHOLDER:

- Class I:** All **Active** full-time and **Active** part-time Employees of the **Policyholder**. Full-time or permanent part-time employee means a person who is scheduled to work 780 hours or more per year and is not defined as an ineligible employee under the Retirement Plan for Employees of the Federal Reserve System. Full-time or part-time employee of the Board of Governors means any person who is in a benefits-eligible position and is appointed into a position with a term of 365 days or more.
- Class II:** Retired Employees of the **Policyholder**. Retired Employees means any person who was insured under this **Policy** as an **Active** full-time or permanent part-time employee immediately prior to their retirement. Coverage must be applied for as a retired employee within 90 days after their retirement date. The **Principal Sum** can be kept the same, can be decreased, but cannot be increased.
- Class III:** Former **Class I** or **Class II Insureds** of the **Policyholder** who have elected to retain their same **Principal Sum** Amounts in lieu of **Principal Sum** reductions after age 75.
- Class IV:** The Retired Employees of the **Policyholder** who retired prior to January 1, 2005 and are part of the closed group on file with the **Policyholder** for the following locations Richmond, New York, and St. Louis.

Note: If **You** suffer an **Injury** resulting in a **Covered Loss** and **You** are covered under more than one class, **We** will pay only one benefit, the largest benefit.

### ELIGIBILITY OF YOUR DEPENDENTS:

Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes **Your** legally married **Spouse/Domestic Partner** and **Your Dependent Child(ren)** and, **Your** legally married **Spouse's Dependent Child(ren)**, and **Your Domestic Partner's Dependent Child(ren)**. A legally married **Spouse/Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your** legally married **Spouse/Domestic Partner**, legally separated **Spouse/Domestic Partner**, former **Spouse/Domestic Partner** are both **Insured's** under the **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

### YOUR EFFECTIVE DATE OF INSURANCE:

- A. For eligible individuals hired prior to the **Policy** Effective Date:  
The **Policy** Effective Date, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.
- B. For eligible individuals hired on or after the **Policy** Effective **Date**:  
On the first day of the month following the date the completed enrollment material is received by the **Policyholder**.

## SECTION II – SCHEDULE

### COVERAGES(S):

#### Classes Covered

24 Hour <b>Accident</b> Protection, Business or Pleasure Excluding Corporate Owned or Leased Aircraft And Substitute Aircraft, Passenger and Crew, H-1	All
Exposure and Disappearance Coverage	All

### BENEFITS:

#### Classes Covered

<b>ACCIDENTAL DEATH BENEFIT</b> <b>Principal Sum:</b>	All
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- Class I:** **You** may purchase an amount of **Principal Sum** from a minimum of \$10,000 to a maximum of \$500,000 in increments of \$5,000. However, amounts applied for must not exceed fifteen (15) times **Your Base Annual Earnings\***, rounded to the next highest \$5,000.

- Class II:** See definition of eligible **Class II** employee in **Eligibility and Classification of Insureds** above.
- Class III:** See definition of eligible **Class III** employee in **Eligibility and Classification of Insureds** above.
- Class IV:**
  - A.** The **Principal Sum You** had elected prior to retiring. **You** are not allowed to make any changes to **Your** coverage, other than cancel.
  - B.** **You** may elect to retain **Your** pre-age 76 **Principal Sum**, as an alternative to reduced **Principal Sums** upon reaching age 76.

\* **Base Annual Earnings** means **Your** base annual earnings including any regularly paid shift differential and any earnings deferred under the Employer’s Section 401(k) Thrift Plan, Section 125, or Section 132 of the Internal Revenue Code, on the date of the accident, excluding overtime pay, bonuses, commissions and any other type of incentives.

**Class I, II and III Only:**

The **Principal Sum** for **Covered Dependents** of a **Class I, II and III** eligible will be the following amounts:

**Spouse/Domestic Partner:** **You** may purchase an amount of **Principal Sum** for **Your Covered Spouse/Domestic Partner** from a minimum of \$10,000 to a maximum of \$300,000 in increments of \$5,000. The **Principal Sum** requested for the **Covered Spouse/Domestic Partner** cannot exceed the lesser of the **Covered Spouse’s/Domestic Partners’ Principal Sum** maximum or **Your** elected **Principal Sum**.

**Dependent Child(ren):** **You** may purchase an amount of **Principal Sum** for **Your Dependent Child(ren)** from a minimum of \$10,000 to a maximum of \$100,000 in increments of \$5,000. The **Principal Sum** requested for the **Dependent Child(ren)** cannot exceed the lesser of the **Dependent Child(ren) Principal Sum** maximum or **Your** selected **Principal Sum**.

**Class I and II Only:**

At age 76, for **You** only, the **Principal Sum** will be reduced based on **Your** previous **Principal Sum** per the following schedule:

<b>Age at Date of Loss</b>	<b>Percent of Principal Sum</b>
76-79	55%
80-84	35%
85 & Over	20%

**Class III Only:**

**You** (active/retirees) will be given until **Your** 77th birthday to inform the **Policyholder’s** record keeper in writing that **You** wish to enroll in **Class III**, reinstating **Your Principal Sum**, not subject to reductions after age 75, at increased rates. The reinstated coverage will be effective the date the written request is received. Once **You** reinstate the higher coverage at increased rates, **Your coverage** will not be subject to reduction according to the Age Reduction Schedule on the **Policy**. **You** cannot request to reverse the **coverage** reinstatement decision at a later time.

	<b>Classes Covered</b>
<b>ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT</b>	All
<b>Principal Sum:</b> Same as above.	
Coma Benefit	All
Permanent and Total Disability Benefit	Class I

**ADDITIONAL BENEFITS:****Classes Covered**

Additional Dismemberment Benefit for Children	All
Carjacking Benefit	All
Common Disaster Benefit	All
Continuation of Insurance Benefit	All
Day Care Benefit	All
Felonious Assault Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Natural Disaster Benefit	All
Rehabilitation Benefit	All
Seat Belt/Air Bag Benefit	All
Spouse/Domestic Partner Benefit	All
Surviving Spouse/Domestic Partner Benefit	All
Therapeutic Counseling Benefit	All
Travel Assistance Plan	All

**SECTION III – DEFINITIONS**

**Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

**Active** and **Actively at Work** describes **You** if **You** are able and available for active performance of all of **Your** regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided **You** are able and available for active performance of all of **Your** regular duties and were working the day immediately prior to the date of **Your** absence.

**Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the **Aggregate Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the **Aggregate Limit of Liability** is not enough to pay full benefits to each **Covered Person**, **We** will pay each one a reduced benefit based upon the proportion that the **Aggregate Limit of Liability** bears to the total benefits which would otherwise be paid.

**Certificate** means this **Certificate** for the **Group Accident Insurance Policy**.

**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.

**Controlled** by, as used in the **Coverages** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

**Coverage(s)** means the event or events described in the **Hazards** of the **Policy** to which benefits and additional benefits apply. The **Hazards** are listed in the **Coverages** Section on the Schedule.

**Covered Accident** means an **Accident** that results in a **Covered Loss**.



## SECTION IV – COVERAGES

### 24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE EXCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, AND SUBSTITUTE AIRCRAFT, PASSENGER AND CREW, H-1

The **Hazards** insured against by the **Policy** are:

A **Covered Injury** sustained by a **Covered Person** anywhere in the world, subject to the terms, conditions, exclusions and limitations under the **Policy**.

#### **Hazard Limitations:**

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Covered Person** is a passenger, riding in or on, boarding or getting off:

- A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
  - 1. medical certificate; and
  - 2. pilot certificate with a proper rating to pilot such aircraft
- B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

#### **Hazard Exclusions:**

**Coverage** is not provided:

- A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft. Or
- B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by or resulting from riding in or on, boarding, or getting off:
  - 1. any aircraft other than those expressly stated in this **Coverage**;
  - 2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**;
  - 3. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of a **Covered Person's** family or household;
  - 4. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
  - 5. any aircraft engaged in a **Specialized Aviation Activity**;
  - 6. any conveyance used for tests or experimental purposes, or in a race or speed test.

#### **Hazard Definitions:**

**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

- 1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
- 2. is the same class of aircraft as the specified aircraft; and
- 3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## EXPOSURE AND DISAPPEARANCE COVERAGE

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the **Covered Person** lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

## SECTION V – BENEFITS

### ACCIDENTAL DEATH BENEFIT

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII General Limitations.

### ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT

If an **Injury** to a **Covered Person** results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

<b>Covered Loss of</b>	<b>Benefit</b>
1. Both Hands or Both Feet	<b>Principal Sum</b>
2. One Hand and One Foot	<b>Principal Sum</b>
3. One Hand or One Foot plus the loss of Sight of One Eye	<b>Principal Sum</b>
4. Sight of Both Eyes	<b>Principal Sum</b>
5. Speech and Hearing	<b>Principal Sum</b>
6. Speech or Hearing	50% of <b>Principal Sum</b>
7. One Hand; One Foot; or Sight of One Eye	50% of <b>Principal Sum</b>
8. Thumb and Index Finger of the same Hand	25% of <b>Principal Sum</b>

#### **Plegia**

1. Quadriplegia (total paralysis of all four <b>Limbs</b> )	<b>Principal Sum</b>
2. Paraplegia (total paralysis of both lower <b>Limbs</b> )	75% of <b>Principal Sum</b>
3. Hemiplegia (total paralysis of upper and lower <b>Limbs</b> on one side of the body)	50% of <b>Principal Sum</b>
4. Uniplegia (total paralysis of one <b>Limb</b> )	25% of <b>Principal Sum</b>

For purposes of this benefit:

1. **Covered Loss** means:
  - a. For a foot or hand, actual severance through or above an ankle or wrist joint;
  - b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - c. Total and permanent loss of sight;
  - d. Total and permanent loss of speech;
  - e. Total and permanent loss of hearing.
2. **Plegia** must continue for 12 consecutive months and be determined by **Our** competent medical authority to be permanent, complete and irreversible paralysis of one or more limbs. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

This benefit is subject to the limitations in Section VIII General Limitations.



## COMA BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** will be equal to 1% of the **Covered Person's Principal Sum** and will be paid each month the **Covered Person** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. when the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. when the **Covered Person** has received a **Coma Benefit** for 100 months.

**Coma** will be determined by **Our** duly licensed physician.

This benefit is subject to the limitations in Section VIII General Limitations.

## PERMANENT AND TOTAL DISABILITY BENEFIT

If **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury** **We** will pay a **Permanent and Total Disability Benefit** provided that **You** become **Permanently and Totally Disabled** within 365 days of the **Injury**; and the **Permanent and Total Disability** continues for twelve (12) months. The benefit payable equals **Your Principal Sum** less any amount payable pursuant to the limitations in Section VIII – General Limitations of the **Policy**.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that **You** are reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the rest of **Your** life.

This benefit is subject to the limitations in section VIII General Limitations.

## SECTION VI – ADDITIONAL BENEFITS

### ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If **You** selected a **Plan** covering **Your** eligible **Dependent Child(ren)**, and a **Covered Dependent Child** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment Benefit**, **We** will pay **You** an additional benefit which will be equal to the benefit amount provided by the **Accidental Dismemberment Benefit**.

### CARJACKING BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death or Accidental Dismemberment and Plegia Benefit**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the **Covered Person** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to 10% of the applicable **Principal Sum** to a maximum of \$25,000.

Verification of the **Carjacking** must be made part of an official police report within twenty-four (24) hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24) hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than the **Covered Person** taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

### COMMON DISASTER BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse/Domestic Partner** are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** suffered in the same **Accident** and within ninety (90) days of such **Accident**, the **Principal Sum** that would have been payable because of **Your Covered Spouse's/Domestic Partner's Accidental Death** will be increased to equal that payable for **Your** loss, provided:

1. the combined benefits of **You** and **Your Covered Spouse/Domestic Partner** are not more than \$1,000,000.

## CONTINUATION OF INSURANCE BENEFIT

If **You**, selected a **Plan** covering **Your Dependents** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, all **Coverages** under the **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than **You**, will be continued automatically for 365 days after the date of the loss at no additional cost.

## DAY CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse/Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 10% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. \$15,000.

If both **You** and **Your Covered Spouse/Domestic Partner** suffer a simultaneous **Covered Loss**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Covered Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Covered Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

## FELONIOUS ASSAULT BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit** or **Accidental Dismemberment and Plegia Benefit** as a result of a violent or criminal act committed by someone other than **You**, a **Fellow Employee** or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to 25% of **Your Principal Sum**, provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises; and
2. the crime directly involves the **Policyholder's** funds or assets.

For purposes of this benefit:

**Fellow Employee** means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the defined violent crime/felonious assault was committed.

**Family** means **Your** parent, step-parent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

**Household** means a person who maintains residence at the same address as **You**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

## HIGHER EDUCATION BENEFIT

If **You** selected a **Plan** covering **Your Dependent Child(ren)** and **You** suffer an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Covered Dependent Child**.

A **Covered Dependent Child** is eligible for the **Higher Education** benefit if on the date of the **Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education** will be equal to 10% of **Your Principal Sum**, to a maximum of \$25,000. This amount will be paid annually for four (4) consecutive years if **Your Covered Dependent Child** continues his or her education. Before this benefit is paid each year, **Your Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no **Covered Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of \$5,000 to the designated beneficiary.

## HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Plegia Benefit**, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the **Covered Person** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Plegia Benefit** is the same **Injury** that requires the **Covered Person** to need the wheelchair.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to the **Covered Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Covered Person's Principal Sum** or \$25,000.

## NATURAL DISASTER BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death or Accidental Dismemberment and Plegia Benefit** as a direct result of a **Natural Disaster**, **We** will pay an additional benefit equal to the lesser of 10% of the **Covered Person's Principal Sum** or \$25,000.

For purposes of this benefit, **Natural Disaster** means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event.

## REHABILITATION BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Dismemberment and Plegia Benefit**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training** in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. \$10,000; or
3. 10% of **Your Principal Sum**.

**Rehabilitation Training** means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation which **You** would not have engaged in except for the **Injury**.

**Reasonable and Customary** expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

**We** reserve the right to make the final determination of what is **Reasonable and Customary**.

#### **SEAT BELT/AIR BAG BENEFIT**

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay to the beneficiary an additional benefit of \$50,000, provided that the **Covered Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

An additional benefit of \$50,000, will be paid if the **Covered Person** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

#### **SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT**

If **You** selected a **Plan** covering **Your Spouse/Domestic Partner** and **You** suffer an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay to, or on behalf of **Your Covered Spouse/Domestic Partner** the actual cost of any professional or trade-training program in which the **Covered Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within twenty-four (24) months from **Your** death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payment under this benefit will be the lesser of 10% of **Your Principal Sum** or \$50,000.

#### **SURVIVING SPOUSE/DOMESTIC PARTNER BENEFIT**

If **You** selected a **Plan** covering **Your Spouse/Domestic Partner** and **You** suffer an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit to **Your Covered Spouse/Domestic Partner**. The monthly benefit will be equal to 1% of **Your Principal Sum** and will be paid for a period of six (6) months.

#### **THERAPEUTIC COUNSELING BENEFIT**

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Dependents** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death** or **Accidental Dismemberment and Plegia Benefit**, and **You** or **Your Covered Dependents** require **Therapeutic Counseling**, **We** will reimburse the actual expense for such counseling to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;
3. **Therapeutic Counseling** must be incurred within one (1) year from the date of the **Covered Loss**.

**Therapeutic Counseling** means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is \$10,000 for any one **Covered Accident**.

## TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse/Domestic Partner** and/or **Child(ren)**, if covered under the **Policy**. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by **Us**. Under the **Policy**, the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

### Medical Evacuation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which based upon **Our** evaluation cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

### Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to his or her **Principal Residence** or to his or her residence in the country where he or she is currently assigned (at his or her option) in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

### Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable which is also subject to the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

### Return of Remains

If a **Covered Person** dies while on a **Covered Trip**, **We** will pay and make arrangements for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

### Visit to Hospital

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. **We** must pre-authorize the transportation for benefits to be payable.

### Return of Child

If a **Covered Person** is traveling with a **Child(ren)**, and due to the **Illness** or **Injury** to the **Covered Person**, such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

The definition of **Child(ren)** as used above will match what is stated in The Health Benefits Program of the Federal Reserve Banks.

### Return of Companion

If a **Covered Person** is traveling with a companion while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one way economy class flight, whichever is less. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

**We** will not provide the **Travel Assistance Plan** if the **Coverage** is excluded under Section VII – General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a MEDICAL EVACUATION, the medical care which is being provided is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or MEDICAL REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this coverage. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of this **Travel Assistance Plan** only, the following definitions apply:

“**Covered Trip**” means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set above.

“**Illness**” or “**Ill**” means a sickness or disease which impairs normal functions of the body.

“**Injured**” “**Injury**” or “**Injuries**” means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

“**Principal Residence**” means the legal domicile of the **Covered Person**.

“**Western Medical Standards**” means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the **Policy**, the definition in the **Travel Assistance Plan** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

**Right of Recovery**

We have the right to recover any benefits which We have paid under this **Travel Assistance Plan** if the **Policyholder** or **Covered Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Covered Person** which were covered under this **Travel Assistance Plan**. We will be reimbursed from such recovery and We will have a lien against that recovery. We have the right to recover any benefits from the **Covered Person** for transportation services and/or expenses, which were not covered under the **Travel Assistance Plan**.

**Reservation of Rights**

We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

**Scope**

**Illness**, as covered under the **Travel Assistance Plan**, is solely covered under the **Travel Assistance Plan**, and in no way supersedes or modifies the other benefits provided under the **Policy**.

To contact **Us** regarding the **Travel Assistance Plan**, the **Covered Person** must call 1-800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

## **SECTION VII – GENERAL EXCLUSIONS**

A loss will not be a **Covered Loss** if it is caused by or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony or an assault;
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous-activity;
7. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
8. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

## **SECTION VIII – GENERAL LIMITATIONS**

**Limitation on Multiple Covered Losses.** If a **Covered Person** suffers more than one loss as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

**Limitation on Multiple Benefits.** If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit, Accidental Dismemberment and Plegia Benefit, Coma Benefit, Permanent and Total Disability Benefit**, as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

**Limitation on Multiple Hazards.** If a **Covered Person** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit.

## SECTION IX - TERMINATION OF INSURANCE

**Your Insurance.** **Your** insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written **Policy**, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of Coverage is subject to all of the termination provisions of the **Policy** with the exception of number 2. above. Please refer to the terms and conditions under The Health Benefits Program of the Federal Reserve Banks for further clarification of eligibility status in this section of the **Policy** contract.

**Your Covered Dependent's Insurance.** Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after **Your Covered Dependent** no longer qualifies as a **Covered Person**.

### Conversion Privilege

**Note:** As of April 15, 2023 the **Conversion Privilege** is no longer available to **Insureds** who are residents of the State of New York.

If **Your** insurance ceases for reasons other than termination of the **Policy** or nonpayment of premium, **You** are entitled to convert **Your Coverage** to an **Individual Accidental Death or Dismemberment (IAD)** policy or to a **Family AD&D (FAD)** policy if **You** selected a **Plan** covering **Your Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. **You** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of **Your** insurance under the Group **Accident Policy**. To convert, **You** must either visit the website or call the phone number listed in the AD&D Conversion Privilege Bulletin provided. **You** do not have to show proof of good health.

The issuance of the **IAD** or **FAD** policy is subject to the following conditions:

1. The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or \$250,000;
2. The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and
4. When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

The **Conversion Privilege** will cease when **You** attain age 76.

## SECTION X - HOW TO FILE A CLAIM

- A. Notice.** **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.
- B. Claim Forms.** **We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and extent of **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.
- C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss** and the proof was provided as soon as reasonably possible.



## SECTION XI - PAYMENT OF CLAIMS

- A. Time of Payment.** We will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Failure to pay a claim within 30 days following **Our** receipt of due proof of loss shall entitle **You** to interest at a rate of 9 (nine) percent per annum from the 30<sup>th</sup> day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. **We** will notify **You** or **Your** assignee of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments will be made within 30 days after the payment.

**B. Who We Will Pay.**

1. **Your Loss of Life.** **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to the beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:

- a. **Your** legally married **Spouse** or **Domestic Partner**;
- b. **Your Child(ren)**;
- c. **Your** parents;
- d. **Your** brothers and sisters;
- e. **Your** estate.

2. **Loss of Life of Your Covered Dependent.** **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.

3. **All Other Claims.** Benefits are to be paid to the **Covered Person**.

- C. Physical Examination and Autopsy.** We have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

- D. Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

## SECTION XII - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

- B. Change or Waiver.** A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

- C. Clerical Error.** A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

- D. Conformity with Statute.** Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

- E. Suit Against Us.** No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. If the **Covered Person** chooses to have the dispute settled by arbitration, arbitration will supersede this provision.
- F. Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.
- G. Voluntary Arbitration.** Any contest to a claim denial under the **Policy** may be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and in accordance with Illinois' Uniform Arbitration Act (710 ILCS 5/1 et seq.) within a reasonable time limit (30 days after the parties agree to arbitrate their dispute is a reasonable time limit for selecting and appointing independent arbitrators, 15 days is a reasonable time limit for an expedited review provision). Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Covered Person**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. The arbitration may be binding on both parties, but in all instances must be entered into on a voluntary basis. Arbitrators must be fair, impartial, and free of any conflicts of interest or the appearance of a conflict of interest.

By voluntarily agreeing to enter into an arbitration proceeding, the parties should be aware and understand that they may be giving up certain rights to have their dispute settled in and by a court of law, except to the extent that Illinois law may provide for judicial review of arbitration proceedings.

This arbitration provision in no way affects a person's ability to file a complaint with the Illinois Department of Insurance, Consumer Services Division, 320 West Washington, Springfield, Illinois 62767.

**The Federal Reserve System**  
**GTU 3809952**  
**Effective: January 1, 2023**

Version: June 2023

# Illinois Civil Marriage Endorsement



**ZURICH AMERICAN INSURANCE COMPANY**  
1299 Zurich Way  
Schaumburg, Illinois 60196

## **THIS ENDORSEMENT CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.**

This endorsement modifies insurance provided under The Federal Reserve System Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the Policy/Certificate:

### **DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:**

The definitions, terms, conditions and any other applicable provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

**Civil Marriage** means a legal union between two individuals of the same or opposite sex as established pursuant to the Religious Freedom and Civil Marriage Fairness Act of 2013. **Civil Marriage** also includes a legal marriage between two individuals of the same or opposite sex established in another jurisdiction.

Terms that mean or refer to a party to a **Civil Marriage** or that may be construed to mean or refer to a party to a **Civil Marriage** are "spouse", "family", "immediate family", "dependent", "next of kin", "husband", "wife", "bride", "groom", "wedlock" and any other such terms that denote a spousal relationship according to the laws and regulations of the State of Illinois.

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the Policy/Certificate to which it is attached.

Effective Date: January 1, 2023

Attached to and forming a part of Policy/Certificate No. GTU 38009952

Signed for Zurich American Insurance Company by: \_\_\_\_\_

A handwritten signature in black ink, appearing to be 'J. W. F.', is written over a horizontal line.

Date: January 1, 2023

**NOTICE OF  
PROTECTION PROVIDED BY  
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance

- o \$300,000 in death benefits
- o \$100,000 in cash surrender or withdrawal values

- Health Insurance

- o \$500,000 in hospital, medical and surgical insurance benefits \*
- o \$300,000 in disability insurance benefits
- o \$300,000 in long-term care insurance benefits
- o \$100,000 in other types of health insurance benefits

- Annuities

- o \$250,000 in withdrawal and cash values

\* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ilhiga.org](http://www.ilhiga.org) or contact:

Illinois Life and Health  
Insurance Guaranty Association  
1520 Kensington Road, Suite 112  
Oak Brook, Illinois 60523-2140  
(773) 714-8050

Illinois Department of Insurance  
4th Floor  
320 West Washington Street  
Springfield, Illinois 62767  
(217) 782-4515

**Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.**

# SANCTIONS EXCLUSION ENDORSEMENT



**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY**

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

## SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

**ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED**



## Privacy Notice

### We Take Important Steps to Protect the Nonpublic Personal Information We Collect About You

Dear Customer:

rev. January 2020

We care about your privacy. That is why we believe in your right to know what nonpublic personal information (“NPI”) we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

<b>Overview</b>	<b>UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION</b>
<b>Why are you receiving this Notice?</b>	Financial institutions, which include the Company, choose how they share your NPI. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services.
<b>What types of Information do we collect?</b>	<p>The types of NPI we collect depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"><li>• Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver’s license number, employment information, information about your income, assets and net worth, and medical information;</li><li>• Information about your transactions with the Company and its affiliates;</li><li>• Information about your insurance coverage, premiums, claims history, and payment history;</li><li>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;</li><li>• Property information and similar data about you or your property, such as property appraisal reports; and</li><li>• Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report.</li></ul> <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>
<b>What do we do with the NPI we collect?</b>	<p>We share your NPI in the course of supporting your insurance coverage or non-insurance products or services, as authorized by law, or with your consent. This includes sharing, as permitted by law, your NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products.</p> <p>These affiliates and nonaffiliated third parties include:</p> <ul style="list-style-type: none"><li>• Financial service providers, such as banks and other insurance companies;</li><li>• Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and</li><li>• Others, such as consumer reporting agencies and insurance information sharing bureaus.</li></ul>

In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, and whether you can opt out of this sharing (or if you are a resident of Vermont, whether you have the right to opt in to allowing this sharing).

Reasons we can share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
<b>For our everyday business purposes</b> – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
<b>For our marketing purposes</b> - to offer our products and services to you	Yes	No
<b>For joint marketing with other financial companies</b>	No	Not Applicable
<b>For our affiliates' everyday business purposes</b> – transaction and experience information	Yes	No
<b>For our affiliates' everyday business purposes</b> – information about your creditworthiness	No	Not Applicable
<b>For our affiliates to market to you</b>	Yes	No
<b>For non-affiliates to market their products to you</b>	No	Not Applicable

Collecting and safeguarding information	
<b>How often do you notify me about your privacy practices?</b>	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. Please review the privacy policy posted on our website, ZurichNA.com. It contains additional information about our practices.
<b>Why do you collect my NPI?</b>	We collect NPI when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
<b>What NPI do we share?</b>	We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?"
<b>How do you safeguard my NPI?</b>	Employees who have access to your NPI are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.



**FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:**

**You have the following individual rights under state law:**

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information, you must submit a request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at [privacy.office@zurichna.com](mailto:privacy.office@zurichna.com). If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information if it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once through any of the above methods, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

**FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS:** You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

<b>Key words and phrases</b>	<b>TERMS YOU SHOULD KNOW</b>
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Definitions	
<b>Everyday business purposes</b>	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: <ul style="list-style-type: none"> <li>Processing transactions, mailing and auditing services;</li> <li>Administering insurance coverage, product, services or claims;</li> <li>Providing information to credit bureaus;</li> <li>Protecting against fraud;</li> <li>Responding to court/governmental orders or subpoenas and legal investigations; and</li> <li>Responding to insurance regulatory authorities.</li> </ul>
<b>Affiliates</b>	Financial or nonfinancial companies related by common ownership or control. <ul style="list-style-type: none"> <li><i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i></li> </ul>

<b>Nonaffiliated Third Parties</b>	<p>Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the services.</p> <ul style="list-style-type: none"> <li>• <i>The Company does not share information with nonaffiliates to market their products to you.</i></li> </ul>
<b>Joint marketing</b>	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>• <i>The Company does not jointly market.</i></li> </ul>

<b>Changes to this Privacy Notice; contact us</b>	<p>We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.</p> <p>If you have any questions about your contract with us, you should contact your agent.</p> <p>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at <a href="mailto:privacy.office@zurichna.com">privacy.office@zurichna.com</a>.</p>
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This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the “Company:”

*American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (together, “the ZNA P&C Companies”), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York.*