OneBeacon
INSURANCE®

OneBeacon America Insurance Company

Canton, Massachusetts

OCCUPATIONAL ACCIDENT

CERTIFICATE OF INSURANCE

FOR

INDEPENDENT CONTRACTOR MEMBERS OF ASSOCIATION FOR DELIVERY DRIVERS, INC.

IMPORTANT NOTICE

THIS INSURANCE IS NOT WORKERS' COMPENSATION INSURANCE.

IT IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION INSURANCE.

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

POLICYHOLDER: **Association for Delivery Drivers, Inc.**

POLICY NUMBER: **216-000-478**

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.

OCCUPATIONAL ACCIDENT
CERTIFICATE OF INSURANCE

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- CERTIFICATE OF ASSUMPTION .... AH 990 ASSU TX 04 12
- NOTICE FOR RESIDENTS OF TEXAS

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY

You are eligible to become an **Insured Person** provided **You** are at least eighteen (18) years of age, **You** are under **Dispatch** (i.e. **Actively at Work**), **You** have completed enrollment material on file with the **Policyholder**, if required, and **You** are:

Class I:

An **Actively at Work Courier** who is a current dues paying member of the Association for Delivery Drivers, Inc. and is enrolled for coverage under the **Policy**. For purposes of the **Policy**, a **Courier** must:

1. own or lease a motorized vehicle. If leased from a courier company or other entity with a shared controlling interest, the lease must be a fair market value; the **Courier** must be obligated to satisfy the terms of the lease even when the **Courier** does not provide services; and any interest rates on the lease must be reasonable based on prevailing interest rates in the market for the same vehicle;
2. be responsible for all expenses such as fuel, vehicle repairs, maintenance and insurance, tolls, occupational accident insurance coverage, and communication devices or scanning equipment;
3. be free to negotiate the fee offered for services and not be prohibited from renegotiating an established fee on an assignment by assignment basis;
4. be paid on a negotiated per completed assignment basis and not by the hour;
5. be free to accept or reject a dispatched assignment based upon conditions such as work hours and schedule;
6. receive an advertising fee or otherwise be additionally compensated for displaying courier company or courier company's customer's signage on the vehicle;
7. not be exclusive to a courier company and the **Courier** must be free to obtain and accept assignments from others;
8. establish his or her own routes and sequence or priority of pick-ups and deliveries;
9. resolve customer complaints jointly with the courier company, or receive and resolve customer complaints;
10. not be required to display the courier company name on the vehicle other than what may be required by applicable government regulations, or on an assignment for security purposes;
11. be able to provide a substitute or engage other couriers with approval or notification of the courier company, so long as the substitute meets the courier company's specifications with respect to driver motor vehicle licensing, drug testing, criminal background checks and insurance requirements. (The **Courier** is primarily responsible for obtaining a substitute or replacement driver but may seek assistance from the courier company or a third party agent.);
12. not be provided with training, other than a general orientation session to familiarize the **Courier** with basic customer pick up or delivery characteristics;
13. receive a 1099 form for federal income tax reporting purposes, not a W-2;
14. be classified as an independent contractor by the courier company who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, or unemployment insurance or for any other purpose.

You cannot be covered by any other **Occupational Accident Policy** issued by **Us**.

If **You** pay premium but are not eligible for coverage or do not qualify for benefits under the **Policy**, **We** will refund any premium paid in error.

FOOT AND BICYCLE MESSENGERS ARE NOT ELIGIBLE FOR COVERAGE UNDER THE POLICY.

YOUR COVERAGE EFFECTIVE DATE

Class I-Courier: If **You** are a **Courier**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above;
3. if an individual written or electronic enrollment form is required, the date upon which the **Policyholder** approves **Your** fully completed and signed written or electronic enrollment form. Such date may not be any earlier than the day after receipt and approval of **Your** enrollment form. Same day coverage is not allowed unless a courier company specifically requests same day coverage for an eligible courier and such request is held on file by the **Policyholder**

Your coverage will not become effective unless the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of 1, 2 or 3 above. If premium is not paid when due, coverage will not be in effect.

YOUR COVERAGE TERMINATION DATE

Class I-Courier: If **You** are a **Courier**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;
2. the last day of the Grace Period, if premiums are not paid when due, subject to the Grace Period;
3. the date **You** request, in writing, that **Your** coverage be terminated; or
4. the date **You** cease to be a member of an eligible Class as described above.

A change in **Your** coverage under the **Policy**, due to a change in **Your** eligible Class or benefit selection, becomes effective on the later of: (1) the date the change in **Your** eligible Class or benefit selection occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Covered Accidents** that occur after the change becomes effective.

Subject to the terms, conditions, exclusions and limitations of the **Policy**, termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while **Your** coverage was in force under the **Policy**.

SECTION II – SCHEDULE OF BENEFITS

PLAN B

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $25,000
- **Accident Commencement Period** .... 365 days

Survivor's Benefit:
- **Principal Sum *** $75,000
- Monthly Benefit Amount $750

Accidental Dismemberment Benefit:
- **Principal Sum *** $100,000
- **Accident Commencement Period** .... 365 days

Paralysis Benefit:
- **Principal Sum *** $100,000
- **Accident Commencement Period** .... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** .... 90 days
- **Waiting Period** .... 10 days
- Benefit Percentage 66.66%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Period **** .... 104 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** .... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 66.66%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Amount** $100,000
- **Maximum Benefit Period** .... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** .... 90 days
- **Deductible Amount** $200
- **Maximum Benefit Period** .... 104 weeks
- Payments to **Preferred Providers** .... 100% of negotiated rate
- Payments to **Non-Preferred Providers** .... 100% of **Usual and Customary Charge(s)** (in no event will payment be less than 80% of the minimum rate paid to a **Preferred Provider**)
- Dental Maximum .... $2,500 per **Accident**
- **Maximum Benefit Amount** per **Accident** $400,000
- Lifetime **Maximum Benefit** $400,000

Limits on **Accident Medical Expense** Benefits:

Physical Therapy, Occupational Therapy, Work Hardening Therapy………. no individual limit, but as any medical service, it is subject to the **Accident Medical Expense Benefit**, the **Combined Single Limit** and the **Aggregate Limit of Liability** stated in the **Policy** for **Occupational Accident Benefits**

Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy .... $1,000 per **Injury**

Ambulance .... one round trip to and from a **Hospital** but not more than $1,000 for any one **Accident**

Air Ambulance .... one round trip to and from a **Hospital** but not more than $7,000 for any one **Accident**

Mental and Nervous – Outpatient .... $25.00 per visit maximum 20 visits for any one **Accident**

Mental and Nervous – Inpatient .... maximum 25 days maximum $1,000 for any one **Accident**

OCCUPATIONAL ACCIDENT LIMITS OF LIABILITY

- **Combined Single Limit** $400,000
- **Aggregate Limit of Liability** $800,000
  (applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

* The **Accidental** Dismemberment Benefit and the Paralysis Benefit will be paid as a Monthly Benefit at 1% of the applicable **Principal Sum**. The payment of this Monthly Benefit will cease upon the earliest of the following: (1) the date the total of the applicable **Principal Sum** has been paid; or (2) the date **You** die. The most **We** will pay for this benefit, as well as the **Accidental** Death Benefit, in total, is **Your** maximum **Principal Sum**, if **You** can recover benefits under more than one of the benefits as a result of the same **Accident**.

At age 65, **Your Principal Sum** will be based on the following schedule:

For Death and Survivor Benefits, Age at Date of **Covered Loss** For Dismemberment and Paralysis Benefits, Age at Date of Benefit Payment	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** will be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

SECTION III – PREMIUM

Monthly Premium Amount:

I. Drivers contracting with a Preferred Courier Company

PLAN B – Standard Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

PLAN B – Heavy Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

II. Drivers contracting with a Standard Courier Company

PLAN B – Standard Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

PLAN B – Heavy Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

III. Drivers contracting with a Courier Company with Surcharge

PLAN B – Standard Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

PLAN B – Heavy Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

IV. Non-Affiliated Drivers

PLAN B – Standard Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

PLAN B – Heavy Vehicle
Full-Time Driver as stated in **Policy** and on Enrollment Form
Part-Time Driver* as stated in **Policy** and on Enrollment Form

* A Part-Time Driver will only be covered for **Accidents** which occur while he or she is working under **Dispatch** to one specific courier company, which he or she has designated at the time of enrollment. If a Part-Time Driver wishes to be exempt from such restriction, he or she must pay the Full-Time Driver rate. A Part-Time Driver is defined as one whose weekly earnings are $275 per week or less.

If **You** enroll on or prior to the fifteenth of the month **You** will pay an amount equal to the full monthly premium. No premium will be payable for the last full or partial month of coverage.

If **You** enroll after the fifteenth of the month **You** will pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** will pay an amount equal to the monthly premium.

Grace Period:

A Grace Period of thirty (30) days will be provided for the payment of any premium due after the first premium. **Your** coverage will not be terminated for nonpayment of premium at the end of the Grace Period if **You** pay the premiums due by the last day of the Grace Period. **Your** coverage will terminate on the last day of the Grace Period if all premiums due are not paid by the last day of the Grace Period.

No Grace Period will be provided if **We** receive notice to terminate **Your** coverage prior to a premium due date.

Waiver of Premium: Subject to the **Policy** remaining in force, all premiums due under the **Policy** with respect to **You** receiving either a **Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit under the **Policy** will be waived. Premiums will be waived from the first premium due date on or after the date the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit begins. Premium payments must be resumed on the premium due date next following the date **Your Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit ceases. If premium payments are not resumed on that date, **Your** coverage under the **Policy** will end on that date. **You** are responsible for reporting Waiver of Premium to the **Program Administrator**.

SECTION IV – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Injury** to **You** results in death within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the **Principal Sum** shown in the **Schedule**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If **You** suffer an **Accidental** Death such that an **Accidental** Death Benefit is payable under the **Policy**, **We** will pay the beneficiary in accordance with the Payment of Claims provision.

Survivor's Benefit (does not apply to a **Non-Occupational Accident**)

The Monthly Benefit Amount will be as described in the **Schedule**. The Monthly Benefit Amount will be paid to **Your** surviving **Spouse** up to the **Principal Sum** shown in the **Schedule**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among **Your** surviving **Dependent Children**. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your** last **Dependent Child** dies or is no longer eligible as defined in the GENERAL DEFINITIONS Section of the **Policy**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will pay only the **Accidental** Death Benefit in accordance with the Payment of Claims provision of the **Policy**. **We** will not pay a Survivor's Benefit.

For purposes of being considered a Survivor who is eligible to receive a **Survivor's Benefit**:

Dependent Child(ren) means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children, from the date of the final decree of adoption, who rely on **You** for more than 50% of their support and are taken as dependents on **Your** Federal Income Tax Return, and who are either: 1) less than 19 (nineteen) years of age; or 2) less than 23 (twenty-three) years of age and enrolled on a full-time basis in a college, university or trade school, or who satisfy neither 1) nor 2), but who prior to age 23 (twenty-three), became incapable of self-sustaining employment by reason of mental retardation or physical handicap. **We** may require proof of such **Dependent Child(ren)'s** incapacity and dependency.

Spouse means **Your** legally married spouse. It includes a person who qualifies as a spouse under Common Law Marriage provided **You** reside in a state that recognizes Common Law Marriage.

Exposure and Disappearance

If **You** are 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 **Your** body has not been found within 365 days after the disappearance, stranding, sinking or wrecking of a power unit or courier vehicle in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered **Accidental** Death within the meaning of the **Policy**. If **You** are subsequently found alive and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to **You** results in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

For **Covered Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Thumb and Index Finger of Same Hand	25%

For purposes of the **Accidental** Dismemberment Benefit, **Loss** will mean:

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If **You** sustain more than one **Loss** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

PARALYSIS BENEFIT (does not apply to a **Non-Occupational Accident**)

If a **Covered Injury** to **You** results in any Type of Paralysis specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**. **Paraplegia** means the complete and irreversible paralysis of both lower **Limbs**. **Hemiplegia** means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body. **Uniplegia** means the complete and irreversible paralysis of one **Limb**. For purposes of this benefit **Limb** means entire arm or entire leg.

If **You** sustain more than one Type of Paralysis as a result of the same **Covered Accident**, only the largest single amount will be considered a **Covered Loss**.

TEMPORARY TOTAL DISABILITY (TTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

TTD Benefit Qualifications.

If a **Covered Injury** to **You** results in **Temporary Total Disability** within the **Disability Commencement Period** shown in the **Schedule**, **We** will pay the **Temporary Total Disability** Benefit specified below, subject to satisfaction of any applicable **Waiting Period** shown in the **Schedule**. **The Disability Commencement Period** starts on the date of the **Accident** that caused such **Injury**. After the **Waiting Period** has been satisfied, the **Temporary Total Disability** Benefit will be payable from the day the **Waiting Period** was satisfied.

TTD Benefit Amount.

The **Temporary Total Disability** Benefit with respect to each week of **Your Temporary Total Disability** during a **Single Period of Total Disability** is equal to the lesser of:

1. the Benefit Percentage (as shown in the **Schedule**) of **Your Average Weekly Earnings**; or
2. the **Maximum Weekly Benefit Amount** shown in the **Schedule**.

In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Temporary Total Disability** Benefit with respect to less than a full **Benefit Week** of **Temporary Total Disability** equals 1/7th of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

TTD Benefit Calculation.

For the purposes of this **Temporary Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- If **You** are a Class I **Courier**:

  Sixty-five percent (65%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then sixty-five percent (65%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as a **Courier** for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as a **Courier** for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

TTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** Disability; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit or courier vehicle. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

TTD Benefit Termination.

The **Temporary Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date the **Maximum Benefit Period** shown in the **Schedule** has been reached;
3. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
4. the date **You** die.

TTD Benefit Definitions.

As used in this **Temporary Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the first day of **Temporary Total Disability** after the **Waiting Period** shown in the **Schedule** for **Temporary Total Disability**, and on the same day of each week thereafter.

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Disability Commencement Period means the time period, shown in the **Schedule**, between the date of the **Accident** that caused the **Injury** and the date that **Temporary Total Disability** must begin for disability benefits to be payable under the **Policy**.

Maximum Benefit Period means, with respect to **Temporary Total Disability**, the maximum period for which benefits will be payable for a **Temporary Total Disability Covered Loss** during a **Single Period of Total Disability**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Temporary Total Disability** is shown in the **Schedule**.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following which are considered separate periods of disability: (1) successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which **You** are not **Temporarily Totally Disabled**; (2) successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least 6 months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or **Temporarily Totally Disabled** means disability that: (1) prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation as a **Courier**; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, You will not qualify for the **Temporary Total Disability** Benefit.

For purposes of this section "**Material and Substantial Duties**" will mean a duty or duties which **You** are required to perform as a **Courier**.

CONTINUOUS TOTAL DISABILITY (CTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

CTD Benefit Qualifications.

If a **Covered Injury** to **You** resulting in **Temporary Total Disability**, subsequently results in **Continuous Total Disability**, **We** will pay the **Continuous Total Disability** Benefit specified below, provided:

1. the benefits payable for the **Temporary Total Disability Covered Loss** ceased solely because the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached, but **You** remain disabled;
2. **You** are under the normal Social Security retirement age, as determined by federal law, on the day after the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached;
3. **You** have been granted a Social Security Disability Award for **Your** disability (If **You** cannot meet the credit requirement for a Social Security Award, **You** cannot qualify for the **Continuous Total Disability** Benefit even if **You** would otherwise qualify);
4. **Your** disability is reasonably expected to continue without interruption until **You** die, and is substantiated by objective medical evidence satisfactory to **Us**;
5. the **Injury** began within the **Disability Commencement Period** shown in the **Schedule**; and
6. the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**. (If the **Temporary Total Disability** was principally due to a **Mental and Nervous or Depressive Condition**, the **Insured Person** does not qualify for a **Continuous Total Disability** Benefit.)

You cannot qualify for a **Continuous Total Disability** Benefit unless **You** qualified for a **Temporary Total Disability** Benefit for the same **Covered Injury**.

Sunset Period: If **You** are not granted a Social Security Award for **Your** disability within two (2) years of the **Injury**, **You** cannot qualify for a **Continuous Total Disability** Benefit even if **You** would otherwise qualify.

CTD Benefit Amount.

The **Weekly Benefit Amount** will be the lesser of the benefit percentage, as shown in the **Schedule**, of the **Average Weekly Earnings**, or the **Maximum Weekly Benefit Amount** as shown in the **Schedule**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Continuous Total Disability** Benefit with respect to less than a full **Benefit Week** of **Continuous Total Disability** equals 1/7th of the **Weekly Benefit** for each day of **Continuous Total Disability**.

CTD Benefit Calculation.

For purposes of this **Continuous Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows:

- If **You** are a Class I **Courier**:

  Sixty-five percent (65%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then sixty-five percent (65%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as a **Courier** for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as a **Courier** for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

CTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Continuous Total Disability Benefit** will be reduced by: (1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your Disability**; (2) Social Security Retirement Benefits; (3) Individual or Group Disability Benefits; (4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; (5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and (6) any income from employment or services, or from leasing **Your** power unit or courier vehicle. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CTD Benefit Termination.

The **Continuous Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **Your** Social Security Disability Award ceases;
3. the date **You** attain age 70;
4. the date the **Maximum Benefit Period** shown in the **Schedule** for **Continuous Total Disability** has been reached;
5. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
6. the date **You** die.

CTD Benefit Definitions.

As used in this **Continuous Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Care means at least quarterly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Continuous Total Disability** on a quarterly basis. These requirements may be waived by **Us**.

Continuous Total Disability or **Continuously Totally Disabled** means disability that: (1) prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience; (2) requires the care and treatment of a **Physician**; and (3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for a **Continuous Total Disability** Benefit.

If **You** can perform an occupation which would provide an annual gross income equal to or greater than either the gross income from wages and/or the net income reported on Schedule C which **You** filed on **Your** most recent federal income tax return filed prior to the **Covered Injury**, **You** are not **Continuously Totally Disabled**. **You** must provide **Us** with such federal income tax return in order to qualify for a **Continuous Total Disability** Benefit.

Maximum Benefit Period means, with respect to **Continuous Total Disability**, the maximum period for which benefits will be payable for a **Continuous Total Disability Covered Loss**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Continuous Total Disability** is shown in the **Schedule**. Benefits payable under the **Temporary Total Disability** Benefit will not be considered **Continuous Total Disability** Benefits for purposes of applying the **Maximum Benefit Period**.

Terms used in this **Continuous Total Disability** Benefit, but which refer to **Temporary Total Disability** and are defined in the **Temporary Total Disability** Benefit, are to be interpreted as defined in that Benefit.

ACCIDENT MEDICAL EXPENSE (AME) BENEFIT

AME Benefit Qualifications.

If **You** suffer an **Injury** that requires **You** to be treated by a **Physician**, within the **Medical Commencement Period** shown in the **Schedule**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Covered Accident Medical Services** received due to that **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown in the **Schedule**, per **Insured Person**, for all **Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Injury**. The **Deductible Amount** for the **Accident Medical Expense** Benefit is the **Deductible Amount** shown in the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Injuries You** sustained in that **Covered Accident**.

AME Benefit Covered Accident Medical Services.

1. **Hospital** semi-private room and board (or room and board in an intensive care unit), **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
2. Services of a **Physician** or a qualified nurse, if under the supervision of a Graduate Registered Nurse (RN), for **Home Health Care** which follows a five (5) day period of **Hospital** confinement and which is prescribed by a **Physician**;
3. Services by a qualified **Physician** for the treatment of a covered **Mental and Nervous Condition** due to a **Covered Injury**. However, such charges will be considered a **Covered Accident Medical Expense** only to the extent that the charges do not exceed $25.00 per visit and are further limited to one visit per day with a maximum of twenty (20) visits. **Hospital** charges for in-patient treatment of a **Mental and Nervous Condition**, whether in a psychiatric **Hospital** or a general **Hospital**, will be considered a **Covered Accident Medical Expense** and will be limited to a maximum of $1,000 for any one (1) **Accident**;
4. Ambulance, including air ambulance, service to or from a **Hospital** for one round trip;
5. Laboratory tests;
6. Radiological procedures;
7. Anesthetics and the administration of anesthetics;
8. Blood, blood products and artificial blood products, and the transfusion thereof;
9. Physical Therapy, Occupational Therapy, Work Hardening Therapy and Chiropractic or Acupuncturist Care as shown in the **Schedule**;
10. Rental of **Durable Medical Equipment**, up to the actual purchase price of such equipment;
11. The initial supply, but not replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes subject to the **Accident Medical Expense** Benefit Exclusions section;
12. Medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
13. Repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the Dental Maximum, if any, shown in the **Schedule**;
14. **Extended Care Facilities**;
15. **Home Health Care**; or
16. **Emergency Care**.

The foregoing **Covered Accident Medical Services** are subject to all of the limits as shown in the **Schedule**.

AME Benefit Exclusions.

In addition to the GENERAL EXCLUSIONS in SECTION VI of the **Policy**, charges for **Covered Accident Medical Services** do not include, and benefits are not payable with respect to, any expense for or resulting from:

- repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
- dentures, bridges, dental implants, or treatment not related to the **Injury**;
- eye glasses or contact lenses;
- hearing aids or hearing examinations;
- that portion of rental expense for **Durable Medical Equipment** that exceeds the usual purchase cost for similar equipment in the locality where the expense is incurred;
- **Custodial Services**;
- **Personal Comfort** or **Convenience Items**;
- services of a Federal, Veteran's, State or Municipal **Hospital** for which **You** are not liable for payment;
- services or treatment which is covered by Medicare;
- that portion of the fee for services or treatment which is more than the **Usual and Customary Charge**;
- cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of an **Injury**;
- services or treatment which are provided for in a settlement or court judgment;
- services or treatment which are covered under any other insurance of any kind;
- services or treatment for which **You** are not legally obligated to pay;
- an **Extended Care Facility** stay that does not follow a **Hospital** confinement of five (5) days or more;
- any mileage charges related to the **Covered Injury** unless authorized by **Us**;
- any translation charges related to the **Covered Injury** unless authorized by **Us**; or
- any lodging charges related to the **Covered Injury** unless authorized by **Us**.

AME Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Ambulatory Medical Center means a facility that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.

Custodial Services means any services which are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services: (1) related to watching or protecting **You**; (2) related to performing or assisting **You** in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and (3) that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Emergency Care means services or treatment provided in a **Hospital** emergency facility or comparable facility to evaluate and stabilize a medical condition, including severe pain, suffered by **You** as a result of an **Injury**, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition due to the **Injury** is of such a nature that failure to get immediate medical care could result in:

1. placing **Your** health in serious jeopardy;
2. serious impairment to bodily functions;

3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Extended Care Facility means an institution that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. is approved by the Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a Graduate Registered Nurse (RN);
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment for **You** in **Your** home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:

1. be approved in writing by the attending **Physician**;
2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
3. begin within seven (7) days after discharge from a **Hospital**; and
4. follow a **Hospital** confinement of five (5) days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of **Your** immediate family; or
2. a person residing in **Your** home.

Hospital means an establishment which is a licensed public or private institution that qualifies as a general hospital or a special hospital as set forth below:

1. as a general hospital, offers services, facilities, and beds for use for more than 24 (twenty-four) hours for two (2) or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy;
2. as a general hospital, regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent;
3. as a special hospital, offers services, facilities, and beds for use for more than 24 (twenty-four) hours for two (2) or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;
4. as a special hospital, has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;
5. as a special hospital, has a medical staff in regular attendance;
6. as a special hospital, maintains records of the clinical work performed for each patient.

Maximum Benefit Period means, with respect to the **Accident Medical Expense** Benefit, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The length of the **Maximum Benefit Period** for **Accident Medical Expense** is shown in the **Schedule**.

Medical Commencement Period means the time period shown in the **Schedule** between the date of the **Accident** that caused the **Injury** and the date that the first medical service or treatment must be incurred for **Accident Medical Expense** Benefits to be payable under the **Policy**.

Medically Necessary means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care supervision or order.

Non-Preferred Provider means a **Physician**, **Hospital**, or other health care provider or an organization of **Physicians**, **Hospitals**, or other health care providers who does not contract with **Us** to provide **Medically Necessary Covered Accident Medical Services** to **You** due to **Injuries** sustained by **You** in a **Covered Accident**. It includes all companies which do not contract with **Us** to provide prescription drugs to **You** at an agreed upon rate.

In the following situations only, a **Non-Preferred Provider** used by **You** will be deemed to be a **Preferred Provider**: 1) there is not a **Preferred Provider** located within **Your** service area, which is defined as a 50 mile radius of **Your** legal residence; 2) **You** receive care under **Emergency Conditions** and cannot reasonably reach a **Preferred Provider**; or 3) the **Medically Necessary Covered Accident Medical Services You** require are not available through a **Preferred Provider**.

For purposes of this provision, an **Emergency Condition or Conditions** is where a **Covered Injury**: 1) renders **You** unable to select a **Physician**, **Hospital**, or other health care provider; 2) requires an emergency responder to select a **Physician**, **Hospital**, or other health care provider without **Your** prior approval; or 3) requires immediate medical care in order to prevent irreparable bodily harm or death and the nearest qualified **Physician**, **Hospital**, or other health care provider is a non-preferred provider.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary** for the care and treatment of **Your Injury**. The term **Personal Comfort or Convenience Item(s)** includes, but is not limited to: (1) a private **Hospital** room, unless **Medically Necessary**; (2) television rental; and (3) **Hospital** telephone charges.

Preferred Provider means a **Physician**, **Hospital**, or other health care provider or an organization of **Physicians**, **Hospitals**, or other health care providers who contract with **Us** to provide **Medically Necessary Covered Accident Medical Services** to **You** due to **Injuries You** sustain in a **Covered Accident**. It includes a company which contracts with **Us** to provide prescription drugs to **You** at an agreed upon rate. A list of **Preferred Providers**, including any changes to such list, will be distributed to **You** not less than annually.

Payment to **Preferred Providers** will be made no later than 45 (forty-five) days after the date on which **We** receive written Proof of Loss that is acceptable to **Us**. **We** will pay them at 100% of their agreed upon rate. **Preferred Providers** will not balance bill **You** for the excess over the agreed upon rate.

Sound Natural Teeth means natural teeth that are either unaltered or fully restored to their normal function and are disease free, have no decay, and are not more susceptible to **Injury** than unaltered natural teeth.

Usual and Customary Charge(s) means a charge that is made for a **Covered Accident Medical Expense** Benefit that: (1) does not include charges that **We** are not legally obligated to pay; (2) is the lesser of the usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred, or the negotiated rate of the **Preferred Provider** designated by **Us**. For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit; and (3) with respect to drugs, is the negotiated rate of the **Preferred Provider** designated by **Us**, if applicable, or 125% of the Average Wholesale Price (AWP), if applicable.

Unless there is a negotiated rate with the provider for a service, treatment, or supply, or unless otherwise noted, **We** will use the local workers' compensation schedule, if applicable, as the basis for the **Usual and Customary Charge**. All services and treatment must be due to a **Covered Injury**.

SECTION V – LIMITATIONS

Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated in the **Schedule**.

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated in the **Schedule**.

Incarceration Limitation.

Benefits being made to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.

SECTION VI – GENERAL EXCLUSIONS

The **Policy** does not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation;
- 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: 1) **Accidental** ingestion of contaminated foods; or 2) bacterial infections contracted through an **Accidental** cut or wound;
- any **Pre-Existing Condition** until You have been continuously covered under the **Policy** for twelve (12) consecutive months;
- **Cumulative Trauma** and/or **Repetitive Conditions**, unless as shown in the **Schedule**;
- **Occupational Disease**, unless (and to the extent as) specifically provided by the **Policy**;
- Hernia of any kind, unless as shown in the **Schedule**;
- Hemorrhoids of any kind, unless as shown in the **Schedule**;
- performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshore and Harbor Workers' Act, or similar coverage;
- war, or any act of war, whether declared or undeclared;
- involvement in any type of active military service;
- any **Injury** for which **You** are entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any loss insured by employers' liability insurance;
- **You** being intoxicated. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle, when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication;
- the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
  - **a.** riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - **b.** performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft;
  - **c.** riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Program Administrator** or an **Insured Person**;
- participation in any of the following activities:

skydiving	hang gliding	parachuting	parasailing
automobile racing or stunts	bungee-jumping	scuba diving	heli-skiing
motorcycle racing or stunts	endurance tests	fire fighting	racing
acrobatic or stunt flying	extreme sport stunts	hunting	

  flight on a rocket-propelled or rocket launched aircraft

  or any other extra-hazardous activity;
- a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**; or
- alcoholism or drug addiction.

SECTION VII – CLAIMS PROVISIONS

Notice. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must include **Your** name and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 866-568-2233. The notice must be sent to the Claims Department at OneBeacon America Insurance Company, P.O. Box 1009, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include **Your** name, the **Policyholder's** name and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible. and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which the claimant will make available to **Us** upon request.

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 one (1) 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**.

Recipient of Payment.

1. 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 **Your** survivors in the following order:
   - **a.** **Your** legally married spouse;
   - **b.** **Your** child(ren);
   - **c.** **Your** parents;
   - **d.** **Your** brothers and sisters; or
   - **e.** **Your** estate.
2. All Other Claims. Benefits are paid to **You**. **You** may direct in writing that all or part of an **Accident Medical Expense** Benefit be paid directly to the party who furnished the service. **You** may change the direction at any time up to the filing of the Proof of Loss. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary, or if there is no beneficiary designated, as set forth above.

Physical Examination and Autopsy. **We** have the right to examine **You** if **Your Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If **You** suffer a **Covered Loss(es)** as the result of **Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You**, **Your** beneficiary or any other person receives payment from the third party, **You**, **Your** beneficiary or any other person agrees to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If **You**, **Your** beneficiary or any other person does not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Rehabilitation. **We** will consider a rehabilitation program for **You** if **You** are receiving benefits under either the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit. The program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined by mutual agreement and benefits payable will continue during **Your** rehabilitation.

Sunset. In no event will a claim made for losses **You** sustain be considered valid and collectible in accordance with the **Policy** unless full details of such claim are presented to **Us** within three years from the date on which written Proof of Loss is required for such claim.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of 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, Wisconsin and Alabama) of the date the written Proof of Loss was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law.

Recovery. In the event **You** make a recovery from a third party for a loss paid under the **Policy**, **You** will reimburse **Us** up to the amount of the benefits made by **Us**.

Subrogation. **We** have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to **You**, **Your** beneficiary or any other person from anyone liable for the **Covered Injury**. If **You**, **Your** beneficiary or any other person recovers from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**, **Your** beneficiary or any other person. **You, Your** beneficiary or any other person agrees to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.

Claims for Workers' Compensation and Other Insurance. No benefits will be payable under the **Policy** for any loss which **You** claim or file under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** will determine **Our** liability under the terms and conditions of the **Policy**. If such a claim is denied, and **You** appeal the denial, no benefits will be paid under the **Policy** until a final disposition of the appeal is issued, at which time **We** will determine **Our** liability. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** which are subsequently paid for under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance.

SECTION IX – GENERAL PROVISIONS

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. 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**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

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.

Clerical Error. A clerical error or omission, whether by the **Policyholder**, the **Program Administrator**, or **Us**, 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**.

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.

Assignment of Interest. The **Policy** is non-assignable.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

Offset Debt. **We** will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from **You** to **Us** against any balance or balances, whether on account of losses or otherwise, due from **Us** to **You**.

SECTION X – GENERAL 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.
- **Accident Commencement Period** means the time period, shown in the **Schedule**, between the date of the **Accident** which caused the **Injury** and the date the **Covered Loss** must occur for death, dismemberment or paralysis benefits to be payable under the **Policy**.
- **Actively At Work** means that **You** are under **Dispatch**.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. 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 **Insured 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.
- **Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are payable under the **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. When the **Combined Single Limit** has been reached, no further benefits will be payable under the **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.
- **Courier** is as described in SECTION I.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while **You** are insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Cumulative Trauma** and/or **Repetitive Conditions** means conditions which impair the normal physiological function of the body over an extended period of time, and which do not arise as the result of a single **Accident**.

- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Injuries You** sustain in a **Covered Accident**, which must be met before the **Accident Medical Expense** Benefit will be paid. The **Deductible Amount** is shown in the **Schedule**.

- **Dispatch** means when **You** are:
  1. in route to pick up a load;
  2. picking up a load;
  3. in route to deliver a load;
  4. unloading a load;
  5. in route after dropping off a load;
  6. waiting for a load if **You** are not at home;
  7. required to perform services by or for a motor carrier; or
  8. performing activities to comply with federal or state laws to satisfy motor carrier or commercial driving requirements.

  Dispatch must be authorized by the person or company which has engaged **You** to transport goods or freight for compensation. **Dispatch** does not include an **Injury** during usual travel between, to, and from work or a bona fide leave of absence or vacation.

  For purposes of the **Policy**, if **You** are performing maintenance and/or repairs on a courier vehicle which **You** own or lease, **You** will be deemed to be under **Dispatch**. **You** must provide proof which is satisfactory to **Us** that the **Injury** was sustained while performing such maintenance or repairs in order to receive **Occupational Accident Benefits** for the **Injury**.

- **Eligible Member** means a person who is described in the ELIGIBILITY portion of SECTION I.

- **Immediate Family Member** means a person who is related to **You** in any of the following ways: **Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild) or any person residing in **Your** home.

- **Injury** or **Injuries** means bodily harm or bodily damage.

- **Insured Person** means a person who: (1) is an **Eligible Member** as described in the ELIGIBILITY portion of SECTION I; (2) has enrolled for coverage; and (3) has coverage in effect according to the terms of the **Policy**.

- **Mental and Nervous** or **Depressive Condition** means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

- **Non-Occupational** means an activity involving **You**, which occurs while **You** are not under **Dispatch**.

- **Occupational** means an activity involving **You**, which occurs or arises out of or in the course of **You** performing services while under **Dispatch**. **Occupational** does not encompass any period of time during the course of everyday travel to and from work or while on vacation.

- **Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

- **Occupational Cumulative Trauma** and/or **Repetitive Conditions** means bodily **Injury** to **You** caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time, where: (1) such condition is diagnosed by a **Physician**; (2) **Your** performance of the activities causing the **Injury** occurred during the **Policy** period, and the onset of the **Injury** occurred and was reported during the **Policy** period; and (3) such activities resulted directly and independently of all other causes in a **Covered Loss**.

- **Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, where: (1) such condition is diagnosed by a **Physician**, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; (2) exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** services; (3) **Your** last day of last exposure to the environmental or physical hazards causing such condition occurs during the **Policy** Period; and (4) such exposure results directly and independently of all other causes in a **Covered Loss**.

- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) **You**; or (2) **Your Immediate Family Member**.

- **Policy** means the Truckers **Occupational Accident** Insurance **Policy**.

- **Policyholder** means the group named on the front page of the **Policy**.

- **Pre-Existing Condition** means a condition for which **You** have sought or received medical advice or treatment during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.

- **Principal Sum**, as applicable to **You**, means the amount of insurance in force under the **Policy** as described in the **Schedule**.

- **Program Administrator** means RSC Insurance Brokerage, Inc. who will review and approve or decline the enrollment form submitted by a **Courier**; distribute certificates of insurance and driver kits; collect and remit premium; and perform other services on behalf of **Us** or the **Policyholder**.

- **Schedule** is SECTION II of this Certificate.

- **Waiting Period** means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit provisions of the **Policy**. **Benefits are not retroactive to the first day of disability**. The **Waiting Period** is shown in the **Schedule**.

- **We**, **Us**, and **Our** refers to OneBeacon America Insurance Company.

- **You** and **Your** refers to the **Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested.

Christopher V. Jerry, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

ONEBEACON AMERICA INSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

CERTIFICATE OF ASSUMPTION

EFFECTIVE NOVEMBER 1, 2012

Policy #216-000-478

Policyholder: Association for Delivery Drivers, Inc.

You are hereby notified that, for all purposes on and after the Effective Date specified above, Atlantic Specialty Insurance Company ("Atlantic Specialty") has assumed liability for the above referenced policy of insurance originally issued by OneBeacon America Insurance Company ("OneBeacon America").

Atlantic Specialty is domiciled in New York, has its principal place of business at 601 Carlson Parkway, Suite 600 in Minnetonka, Minnesota 55305, and is licensed in the state of Texas.

On and after the Effective Date, Atlantic Specialty has assumed all rights and duties under the policy and all references in the policy and certificate to OneBeacon America are hereby changed to Atlantic Specialty. All correspondence and inquiries such as policy changes and notices of claims should continue to be submitted to the current addresses and phone numbers, but under the company name of Atlantic Specialty Insurance Company.

This Certificate of Assumption forms a part of and has been attached to the insurance policy referenced above, issued by OneBeacon America.

IN WITNESS WHEREOF, Atlantic Specialty Insurance Company has caused this Certificate of Assumption to be duly signed and issued.

Secretary President

Assumption Form #AH 990 ASSU TX 04 12

NOTICE
FOR RESIDENTS OF TEXAS

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Atlantic Specialty Insurance Company /OneBeacon's toll-free number for information or to make a complaint at:

1-800-527-1255

You may also write to Atlantic Specialty Insurance Company/OneBeacon at:

Atlantic Specialty Insurance Company
c/o OneBeacon Insurance Group
44 Whippany Road
Morristown, NJ 07960

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771
Web: http//www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or Atlantic Specialty Insurance Company/ OneBeacon first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of this document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Atlantic Specialty Insurance Company/OneBeacon's para informacion o para cometer una queja al:

1-800-527-1255

Usted tambien puede escribir a Atlantic Specialty Insurance Company/OneBeacon al:

Atlantic Specialty Insurance Company
c/o OneBeacon Insurance Group
44 Whippany Road
Morristown, NJ 07960

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion a cerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771
Web: http//www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclame, debe comunicarse con el agente o Atlantic Specialty Insurance Company/OneBeacon primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas

UNA ESTE AVISO A SU POLIZA:

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

TX Notice 11/08