GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

RISK STRATEGIES
7530 LUCERNE DRIVE, SUITE 101
CLEVELAND, OH 44130
PRODUCER 235475

GREAT AMERICAN INSURANCE COMPANY
OCCUPATIONAL ACCIDENT INSURANCE POLICY DECLARATIONS
SCHEDULE OF BENEFITS

Item 1:

Group name:	Independent Contractors who are members to the Association for Delivery Drivers.
Eligible persons:	Independent Contractors in the state of California between the ages of 18 and 75 who are members of the Association for Delivery Drivers while engaged in delivery business for themselves or under contract with another company. Class A CDL operators must be between the ages of 23 and 75. Does not include helpers.
Policy holder:	ASSOCIATION FOR DELIVERY DRIVERS P.O. BOX 123 GAYLORDSVILLE, CT 06755
Policy number:	OA3735899-02
Effective date:	04/01/2023
Anniversary/ Termination date:	04/01/2024 12:01 a.m. standard time at the address of the policyholder stated above

Item 2: **SCHEDULE OF BENEFITS: PLAN FOR ASSOCIATION FOR DELIVERY DRIVERS PLAN C**
PLEASE REFERENCE THE SCHEDULE OF BENEFITS (F32368) ATTACHED TO THIS POLICY. YOUR POLICY MAY INCLUDE A SUPPLEMENTAL SCHEDULE OF BENEFITS (F32367) IF APPLICABLE OPTIONAL RIDERS ARE ATTACHED.

Item 3: The coverage provided by this policy is limited and is subject to certain conditions. Please read the policy carefully. This policy does not provide workers compensation coverage nor provide coverage for sickness. *Full Social Security Retirement Age (SSRA) will vary depending upon your date of birth. If you are to reach your full SSRA before satisfying the waiting period, you may not qualify for continuous total disability benefits.

Item 4: Please report claims to 1-833-444-0161.

Item 5: The following forms are attached and made a part of this policy:
SDM526 (02-19), F.32175 (02/10), F.32466 (05/13), F.32368 (10/09), F.32457 (08/12), F.32469 (05/13), SDM880 (12/15), F.032180 (09/01), F.32271 (04/10), F.32468 (06/12), IL7268 (09/09)

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Policy Number: OA3735899-02
Policy Effective Date: 04/01/2023
Policy Anniversary/Termination Date: 04/01/2024
Plan C

OCCUPATIONAL ACCIDENT SCHEDULE OF BENEFITS

The list of benefits is only a brief description of the actual coverages. Certain exclusions and limitations do apply. For complete details please refer to your policy. In the event of any conflict between the information listed here and the actual policy language, the insurance policy will govern in all cases.

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON OCCUPATIONAL	PASSENGER
ACCIDENTAL DEATH AND DISMEMBERMENT			
MAXIMUM BENEFIT AMOUNT	$350,000	Not Covered	Not Covered
SURVIVOR'S BENEFIT (LUMP SUM)	(($50,000)+$1,500 Per Month Up To 200 Months)	Not Covered	Not Covered
INCURRAL PERIOD	52 Weeks	Not Covered	Not Covered
ACCIDENTAL DISMEMBERMENT – INCLUDING PARALYSIS AND SEVERE BURN	Included In Principal Sum	Not Covered	Not Covered
ACCIDENTAL MEDICAL EXPENSE			
MAXIMUM BENEFIT AMOUNT	$1,000,000	Not Covered	Not Covered
COMMENCEMENT PERIOD	90 Days	Not Covered	Not Covered
DEDUCTIBLE	$200	Not Covered	Not Covered
INCURRAL PERIOD	104 Weeks	Not Covered	Not Covered
ACCIDENTAL DENTAL			
MAXIMUM BENEFIT AMOUNT	$2,500 Per Accident	Not Covered	Not Covered
CHIROPRACTIC CARE, OCCUPATIONAL THERAPY, PHYSICAL THERAPY			
MAXIMUM BENEFIT AMOUNT	No Sublimit Applies	Not Covered	Not Covered
MAXIMUM NUMBER OF TREATMENTS	No Sublimit Applies	Not Covered	Not Covered
TEMPORARY TOTAL DISABILITY			
MAXIMUM BENEFIT AMOUNT	66% Avg Wkly Earnings Up To Wkly Max/Min Amts req by CA Labor Code 4453(a)(10).	Not Covered	Not Covered
WAITING PERIOD	7 Days Retroactive	Not Covered	Not Covered
DURATION-MAXIMUM BENEFIT PERIOD	104 Weeks	Not Covered	Not Covered
COMMENCEMENT PERIOD	90 Days	Not Covered	Not Covered
CONTINUOUS TOTAL DISABILITY			
MAXIMUM BENEFIT AMOUNT	66% Avg Wkly Earnings Up To Wkly Max/Min Amts req by CA Labor Code 4453(a)(10).	Not Covered	Not Covered
WAITING PERIOD	104 Weeks	Not Covered	Not Covered
DURATION-MAXIMUM BENEFIT PERIOD	Up To Social Security Retirement Age	Not Covered	Not Covered
CERTIFICATE COMBINED SINGLE LIMIT/AGGREGATE	**$1,000,000 CSL/$2,000,000 Aggregate**		

This coverage is not Workers Compensation Insurance or for any purpose except occupational accidents (unless non- occupational benefits apply). This policy does not cover disease unless otherwise endorsed by rider and scheduled on a Supplemental Schedule of Benefits. If any other coverage riders apply they will be endorsed onto the policy and all applicable benefit limits will be scheduled on the Supplemental Schedule of Benefits.

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Policy Number: **OA3735899-02**
Policy Effective Date: **04/01/2023**
Policy Anniversary/Termination Date: **04/01/2024**
Plan C

OCCUPATIONAL ACCIDENT SUPPLEMENTAL SCHEDULE OF BENEFITS

The list of benefits is only a brief description of the actual coverages. Certain exclusions and limitations do apply. For complete details please refer to your policy. In the event of any conflict between the information listed here and the actual policy language, the insurance policy will govern in all cases.

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON OCCUPATIONAL	PASSENGER
OCCUPATIONAL DISEASE BENEFIT			
MAXIMUM ACCIDENTAL MEDICAL BENEFIT PER INJURY/LIFETIME	$10,000/$20,000]	Not Covered	Not Covered
MAXIMUM BENEFIT PERIOD PER INJURY	10 Weeks	Not Covered	Not Covered
TEMPORARY TOTAL DISABILITY			
MAXIMUM BENEFIT PERIOD PER INJURY	Included in the Above Noted Limits	Not Covered	Not Covered

This coverage is not Workers Compensation Insurance or for any purpose except occupational accidents (unless non- occupational benefits apply). This policy does not cover disease unless otherwise endorsed by rider and scheduled on the Supplemental Schedule of Benefits. If any other coverage riders apply they will be endorsed onto the policy and all applicable benefit limits will be scheduled on the Supplemental Schedule of Benefits. All benefits included in the Supplemental Schedule of Benefits contribute to and are not in addition to the certificate Combined Single Limit applicable for any one Accident and to the Certificate Aggregate for all Accidents.

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Independent Contractor
Occupational Accident Insurance Coverage
TABLE OF CONTENTS

Non-Duplication of Workers' Compensation Benefits. No direct benefits are payable under this Policy to or on behalf of any Insured, Authorized Passenger or Designated Beneficiary who is covered by any Workers Compensation, Employers Liability, Occupational Disease or similar law or Policy. In the event duplicate benefits are paid under this Policy and under any Workers Compensation, Employers Liability, Occupational Disease or similar law or Policy for the same or substantially the same Injury, the Insured, Authorized Passenger or Designated Beneficiary must immediately reimburse the Company for all of the benefits that were paid under this Policy.

SECTION I

GENERAL DEFINITIONS

Defined terms in this policy will be designated by initial caps.

Accident means a sudden, abrupt, discrete, and unexpected event that (1) occurs while coverage is in force for an Insured Person under this Policy in accordance with the EFFECTIVE PERIOD described in SECTION II of this Policy, (2) takes place at a discrete, identifiable time and place, rather than something which continues, progresses, or develops, and (3) results in physical Injury

Administrator means an Administrator named in the Schedule of Benefits.

Authorized Passenger means a passenger: (1) who is listed as an Authorized Passenger in the Schedule of Benefits provided by the Certificateholder; (2) who is a minimum of 16 years of age; (3) who does not drive the vehicle, load or unload cargo, secure or unsecure cargo, fuel or participate in any other activity of the vehicle; and (4) for whom the required premium has been paid. In no event will the term "Authorized Passenger" include a hitchhiker.

Co-Owner means a person who has partial ownership of a vehicle which is being operated by an Independent Contractor for the purpose of performing Occupational services,

Contractee means the person, firm or other entity with whom the Independent Contractor has contracted to provide Occupational services. The Contractee is identified on the Schedule of Benefits as the "Contractee" or "Participating Contractee."

Covered Contract means a written contract between the Contractee and the Independent Contractor. To be a "Covered Contract", such contract must meet all of the following conditions:

1. it must be signed by both the Contractee and the Independent Contractor;
2. it must provide that the Independent Contractor is responsible for:
    a. vehicle or equipment maintenance;
    b. vehicle or equipment operating costs, including but not limited to:
        i. fuel,
        ii. repairs,
        iii. physical damage, and
        iv. all other operating expenses of the Independent Contractor's business.
3. it must provide that the Independent Contractor is to be compensated on a basis other than one based solely on time expended in performing work;
4. it must provide that the Independent Contractor, and not the Contractee, shall have the responsibility for determining the time, means, and method of performing Occupational Services; and
5. it must provide that the Independent Contractor is an Independent Contractor and not an employee of the Contractee.

Covered Loss(es) means one or more of the losses or expenses described as such in Section IV of this Policy.

Dependent Child(ren) means the Insured Person's unmarried children (including natural children from the moment of birth, step- or foster-children, or adopted children, from the moment of placement in the home of the Insured Person) who are under age 19 (24 if attending an accredited institution of higher learning on a full-time basis) and primarily dependent on the Insured Person for support and maintenance at the time of the Insured Person's death caused by an Occupational Injury. It also includes any unmarried Dependent Child(ren) of the Insured Person who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured Person for support and maintenance at the time of the Insured Person's death caused by an Occupational Injury. The Company may require proof of the Dependent Child(ren)'s incapacity and dependency within 60 days before the Dependent Child(ren) reach(es) the age limit specified above. The Company may request that satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency be submitted to the Company on an annual basis. If the requested proof is not furnished within 31 days of the request, such child(ren) shall no longer be considered Dependent Child(ren) as of the end of that 31 day period.

Functional Capacity Examination (FCE) means an examination performed by a physical therapy professional to evaluate and estimate physical limitations. For the purposes of Continuous Total Disability, the Functional Capacity Examination will be required to be administered by a licensed Occupational Therapist and confirmed by a licensed Physician each of whom must meet with our prior approval

Immediate Family Member means a person who is related to the Insured Person 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 and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Incurral Period is the time period within which the Covered Loss must be incurred. The length of the Incurral Period will be shown in the Schedule. The Incurral Period begins on the date of the Accident causing the Covered Injury.

Independent Contractor means a person who: (1) owns or leases a vehicle or equipment (from an entity other than this Policyholder) which he or she is operating for the purpose of performing Occupational services, (2) is an Independent Contractor as defined by law, and (3) is not an employee of this Policyholder or Contractee and (4) has entered into an agreement with the Contractee, under a Covered Contract, to provide Occupational services. Independent Contractor includes a Co-Owner, but only if the Co-Owner otherwise meets the definition of Independent Contractor.

Injury means physical Injury to an Insured Person caused by an Occupational Accident while coverage is in force under this Policy, which results directly and independently of all other causes in a Covered Loss. Injury does not include a repeated, continuous, or progressive process, disease, or condition. All Injuries sustained by the same Insured Person in any one Accident shall be considered a single Injury.

Insured means a person who: (1) is a member of an eligible class as described in the Eligible Persons section of the Schedule of Benefits, and (2) has enrolled for coverage, and (3) has paid the required premium. However, an Insured does not include any person covered under this Policy solely as an Authorized Passenger.

Insured Person means an Insured or, if Authorized Passenger coverage is Scheduled on the Schedule of Benefits, an Authorized Passenger.

Occupational means, with respect to an activity, Accident, incident, circumstance or condition involving an Insured, that the activity, Accident, incident, circumstance or condition is proximately caused by the Insured's performing services within the course and scope of contractual obligations for the Contractee. With respect to an Authorized Passenger, the term Occupational means that the activity, Accident, incident, circumstance or condition occurs during and is proximately caused (a) while the Insured is performing Occupational services and (b) by and during the Authorized Passenger's riding as a passenger in or on (including getting in or out of, or on or off of) the vehicle. Occupational encompasses any period of time during everyday travel between locations where services are to be performed. Occupational does not encompass any period of time during the course of travel between an Insured's residence and any place at which that Insured performs Occupational services. Occupational also does not encompass any period of time during travel to or from locations of personal business during the course of travel to locations where services are to be performed.

Occupational Assessment means a determination of vocational capabilities. The determination process may include 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, and vocational alternatives.

Occupational Cumulative Trauma means Injury to an Insured 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) the Insured's last day of last performance of the activities causing the Injury occurred while the Insured is covered under this Policy, 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 the Insured's 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 the Insured performs Occupational services, (3) the Insured's last day of last exposure to the environmental or physical hazards causing such sickness occurs while the Insured is covered under this Policy, 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 neither: (1) the Insured Person nor (2) an Immediate Family Member of the Insured Person nor (3) retained by the Contractee.

Policyholder means the entity to whom this Policy is issued as shown on the Schedule.

Pre-Existing Condition means a health condition for which an Insured Person has sought or received medical advice or treatment at any time during the twelve months immediately preceding his or her effective date of coverage under this Policy.

Schedule or Schedule of Benefits means the Schedule shown in the Schedule of Benefits for this Policy, which is attached to and made a part of this Policy.

Spouse means the person to whom the Insured Person is legally married and with whom the Insured Person co-habits in a continuous and open manner.

SECTION II

EFFECTIVE PERIOD
Policy Effective, Expiration, and Termination Dates

Policy Effective Date. The effective period of this Policy begins on this Policy Effective Date shown on the Schedule of Benefits, at 12:01 A.M. Standard Time at the address of this Policyholder where this Policy is delivered.

Policy Expiration Date. The expiration of this Policy is the Anniversary/Termination Date shown on the Schedule of Benefits at 12:01 A.M. Standard Time at this Policyholder's address.

Policy Termination Date. The effective period of this Policy will end at 12:01 A.M. Standard Time at this Policyholder's address on the earliest of:

1. this Policy Anniversary/Termination Date shown on the Schedule of Benefits page, unless renewed before that date;
2. the premium due date, if we do not receive a required premium payment, in full, on or before that date;
3. the date specified in any written notice of the Company's intent to terminate this Policy, which will be at least thirty-one (31) days after the date the Company sends such notice to this Policyholder's and/or Contractee's last known mailing address; or
4. the date specified in any written notice of the Policyholder's intent to terminate this Policy, which must be at least thirty-one (31) days after the date this Policyholder sends such notice to the Company.

Termination of this Policy will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

Policy Non-Renewal. If the Company determines to not offer renewal terms for this Policy, a notice to this Policyholder will be mailed no less than 30 days prior to the Anniversary/Termination Date shown on the Schedule of Benefits.

Independent Contractor's Effective and Termination Dates

Independent Contractor's Effective Date. An Independent Contractor's coverage under this Policy begins on the latest of:

1. this Policy Effective Date;
2. the date the person becomes a member of an eligible class of persons described in the Description of Eligible Persons section of the Schedule of Benefits;
3. if individual enrollment is required, the date written enrollment is received by the Contractee, or
4. the date on which the first premium payment for that Independent Contractor is received in full by the Company on or before its due date.

If the first premium payment for that Independent Contractor is paid in full when due, coverage begins on the latest of item 1, 2, or 3 above. If the first premium is not paid in full when due, coverage for that Independent Contractor will not go into effect.

Independent Contractor's Termination Date. An Independent Contractor's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the first premium due date on which a premium payment for that Independent Contractor is not paid in full when due;

3. if the Independent Contractor requests, in writing, that his or her coverage be terminated, the effective date of that termination;
4. the effective date of any written notice of termination issued by the Company to the Policyholder; or
5. the first date the Independent Contractor ceases to be a member of any eligible class(es) of persons as described in the Description of Eligible Persons section of the Schedule of Benefits.

Authorized Passenger's Effective and Termination Dates

Authorized Passenger's Effective Date. An Authorized Passenger's coverage under this Policy begins on the latest of:

1. this Policy Effective Date;
2. the Independent Contractor's Effective Date;
3. the date the person becomes a member of an eligible class of persons described in the Eligible Persons section of the Schedule of Benefits;
4. the date the Passenger Authorization Form is completed and received by the Contractee; or
5. the date on which the first premium payment for that Authorized Passenger is received in full by the Company on or before its due date.

If the first premium for that Authorized Passenger is paid in full when due, coverage is effective on the latest of item, 1, 2, or 3 above. If the first premium payment for an Authorized Passenger is not paid in full when due, coverage for that Authorized Passenger will not go into effect.

Authorized Passenger's Termination Date. An Authorized Passenger's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the first premium due date on which a premium payment for that Authorized Passenger is not paid in full when due;
3. the first date the Authorized Passenger ceases to be a member of an Eligible Class of persons described in the Eligible Persons section of the Schedule of Benefits;
4. the date coverage ends for any reason for the Independent Contractor with respect to whom he or she is an Authorized Passenger; or
5. the last day of the period for which the Authorized Passenger's coverage was elected and for which the premium has been received in full by the Company.

A change in an Insured Person's coverage under this Policy due to a change in his or her eligible class or benefit selection becomes effective on the later of: (1) the date the change in his or her eligible class or benefit selection is requested by the Insured Person and approved by the Company issuing this insurance; or (2) if the change requires a change in premium, the date the first changed premium payment is paid in full. However, a change in coverage applies only with respect to Accidents that occur after the change becomes effective.

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 the Insured Person's coverage was in force under this Policy.

SECTION III

PREMIUM

Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premium section of the Schedule of Benefits. The Company may change the required premiums due on any Policy anniversary date, as measured annually from this Policy Effective Date, by giving this Policyholder at least thirty-one (31) days' advance written notice of the change. The Company may change the required premiums as a condition of any renewal of this Policy. The Company may also change the required premiums at any time when any change affecting premiums is made in this Policy.

Certificateholder's Premium. The Premium Rate for coverage under this Policy for each Insured Person is shown on the Schedule of Benefits and shall be payable as follows:

1. Insured Persons who are enrolled on or before the monthly cut-off day selected by this Policyholder or Contractee shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage.
2. Insured Persons who are enrolled after the monthly cut-off day selected by this Policyholder or Contractee shall pay the full monthly premium on the first day of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, Insured Persons shall pay the full

monthly premium.

Grace Period. A Grace Period of thirty-one (31) days will be provided for the payment of any premium due after the first premium. This Policy will not be terminated for non-payment of premium during the Grace Period if this Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid in full by the last day of the Grace Period.

If the Company expressly agrees to accept late payment of a premium without terminating this Policy, the Company does so in accordance with the Noncompliance with Policy Requirements provision in Section VIII of this Policy. In that case, this Policyholder will be liable to the Company for any unpaid premiums for the time this Policy is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by the Company in the collection of all overdue amounts.

No Grace Period will be provided if the Company receives notice to terminate this Policy prior to a premium due date.

Waiver of Premium. Subject to this Policy remaining in force, all premiums due under this Policy will be waived with respect to an Insured Person who is receiving either a Temporary Total Disability Benefit or Continuous Total Disability Benefit under this Policy. Premiums will be waived beginning with the first premium due date on or after the date the disability begins. Premium payments must be resumed on the premium due date next following the date the Insured Person's Temporary Total Disability Benefit or Continuous Total Disability Benefit ceases. If premium payments are not resumed on that date, that Insured Person's coverage under this Policy automatically ends on that date.

SECTION IV

BENEFITS

Our obligation, if any, to pay benefits is limited as described in this Section IV and in Section V – Limits of Liability.

For the purpose of computing the benefits to which an Insured Person is entitled under this Policy, all Injuries sustained by the same Insured Person in any one Accident shall be considered a single Injury.

Principal Sum

As applicable to each Insured Person, Principal Sum means the amount of insurance in force under this Policy on the date of the Accident, as described in the Schedule.

Accidental Death and Dismemberment Benefits

The Company shall have the right to develop a structured benefit distribution plan for the payment of any benefit(s) payable under the Policy, whether through an annuity or otherwise. We do not need the consent or agreement of the Insured Person, beneficiary, or any other person to develop and implement such a plan. Upon the purchase of an annuity, the obligation to make any and all future payments under the Policy will be transferred to the company issuing the annuity. It is agreed that, in that event, the Insured Person or Designated Beneficiary will rely solely on that company to satisfy any and all further obligations for such benefits under the Policy and no further demands or claims can or will be made against the Company for such benefits. If any person entitled to receive benefits is a minor or otherwise not competent to give a valid release, such benefits shall be paid to such person's legally appointed guardian or conservator. The Principal Sum as referenced in the Accidental Death and Dismemberment section of the Schedule of Benefits applies as the Maximum Benefit Amount applying to all benefits payable for Accidental Death and Accidental Dismemberment-including Severe Burn and Paralysis.

(Example: Principal Sum of $250,000 is available as a Lump Sum of $50,000 and Monthly Benefit of $2,000 up to 100 months. The Insured Person has a covered Injury resulting in Paralysis. It is determined that the Paralysis qualifies as Hemiplegia with a benefit available up to 50% of the Principal Sum payable as 50% of the Lump Sum, or $25,000 and 50% of the Monthly Benefit or $1,000 a month up to 100 months. If as a result of the same Accident, the Insured Person's Death occurs within the Incurral Period, as stated in the Scheduled of Benefits, the Paralysis Benefit would cease. The remaining Lump Sum and Monthly Benefit amounts are then available as an Accidental Death Benefit payable as a Lump Sum of $25,000 and Monthly Benefit as a Survivor Benefit based upon the remaining amount of the Principal Sum not to exceed $2,000 per month up to 100 months and subject to the terms as described under the Survivor Benefit.)

Accidental Death Benefit

If Injury to the Insured results in death within the Incurral Period shown in the Schedule, the Company will pay a Lump Sum as a Death Benefit and a Monthly Benefit as a Survivor Benefit, subject to the terms and conditions described in the Survivor's Benefit section below. The Incurral Period starts on the date of the Accident that caused such Injury.

Survivor's Benefit

If an Insured Person suffers Accidental death such that a Lump Sum Death Benefit is payable under the Policy, the Company will pay a Survivor's Benefit to the surviving Spouse, up to the Principal Sum, less any Lump Sum Death Benefit as shown in the Schedule and any benefit paid under the Accidental Dismemberment Benefit as described in the Policy. The Monthly Survivor's Benefit Amount is determined by dividing the remainder of the Principal Sum after payment of any Lump Sum and Monthly Benefits for Accidental Dismemberment or Lump Sum for a Death Benefit by the number of months shown in the Schedule of Benefits. If the Insured Person is not survived by a Spouse, or if the Insured Person's Spouse dies or remarries before the Survivor's Benefit is exhausted, the Company will pay or continue to pay the Survivor's Benefit to the Insured Person's surviving Dependent Children, if any. If there is more than one surviving Dependent Child, the Survivor's Benefit will be distributed equally among the surviving Dependent Children.

The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date the Spouse dies or remarries, if there are no Dependent Children;
2. as to each Dependent Child, the date that Dependent Child dies or is no longer within the definition of Dependent Child as defined in Section I of the Policy; or
3. the date the Principal Sum has been paid.

If the Insured Person is not survived by a Spouse or Dependent Child, the Monthly Survivor Benefits will not be paid and the Company will pay only the Lump Sum Death Benefit amount to the Designated Beneficiary in accordance with the Payment of Claims provisions of the Policy.

Exposure and Disappearance

If, by reason of an Occupational Accident, an Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss which is otherwise covered under the Policy, the loss will be considered a Covered Loss under the terms of the Policy.

If the body of an Insured Person has not been found within one year after the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which that Insured Person was an occupant, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered Accidental Death within the meaning of the Policy. If, within seven (7) years of the reported date of death or disappearance, the Insured Person is later found living, all benefits paid must be immediately refunded to the Company.

Accidental Dismemberment including Severe Burn and Paralysis Benefit

All Injuries sustained by the same Insured Person in any one Accident shall be considered a single Injury**.**

If an Insured Person as a result of the same Accident sustains more than one kind of Accidental Dismemberment, Severe Burn or Paralysis loss described below, only one amount, the largest, will be paid. Note that any payments of benefit under the Accidental Dismemberment Benefit, including Severe Burn Benefit and Paralysis Benefit sections of the Policy are deducted from the Principal Sum and reduce any available benefits for Accidental Death resulting from the same Accident or Injury.

Lump Sum and Monthly Benefit: If Injury to the Insured Person results in any one of the Losses specified below, within the Incurral Period as shown in the Schedule as measured from the date of the Accident that caused such Injury, the Company will pay a percentage of the Lump Sum and Monthly Benefit equal to the Percentage of the Principal Sum shown below for that Loss. Benefits will be payable in equal monthly payments up to the Maximum Monthly Benefit Amount shown in the Schedule, subject to the maximum benefit period shown in the Schedule of Benefits. The payment of the monthly benefit ceases on the earlier of: (1) in the case of paralysis, the date the Insured Person is no longer paralyzed or (2) the date the Insured Person dies or (3) the date the total amount of monthly benefits paid equals the Percentage of the Principal Sum shown below for that Loss.

Dismemberment Benefit Schedule
All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

For 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%
Speech and Hearing in Both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Four Fingers of Same Hand	25%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%
All Toes of Same Foot	13%
One Thumb	10%
One Finger	2%
One Toe	1%

"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 hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of an arm or leg means complete severance through or above the shoulder or hip joint. "Loss" of four fingers means complete severance through or above the metacarpophalangeal joint of all four digits. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Loss" of all toes means complete severance through or above the metatarsophalangeal joint of all five digits. "Loss" of one thumb means complete severance through or above the metacarpophalangeal joint of the digit. "Loss" of one finger means complete severance through or above the metacarpophalangeal joint of the digit. "Loss" of one toe means complete severance through or above the metatarsophalangeal joint of the digit.

If an Insured Person as a result of the same Accident sustains more than one Loss, only one amount, the largest, will be paid.

Severe Burn Benefit Schedule
All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

The Accidental Dismemberment Benefit includes Severe Burn as a covered loss.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area due to an Injury that is a full-thickness or third-degree burn as determined by a Physician. (A full- thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

Specified Body Area	Maximum Percentage of Principal
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint (Right)	22.5%
Hand and Forearm Below Elbow Joint (Left)	22.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Right)	13.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Left)	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints (Front)	36%
Torso Below Neck to Shoulder Joints and Hip Joints (Back)	36%
Thigh Below Hip Joint to Knee Joint (Right)	9%
Thigh Below Hip Joint to Knee Joint (Left)	9%
Foot and Lower Leg Below Knee Joint (Right)	27%
Foot and Lower Leg Below Knee Joint (Left)	27%

If only one of the Insured Person's body areas specified in the table above is Severely Burned in an Accident and 100% of the surface of that specified body area is Severely Burned, the benefit payable is 100% of the Maximum Percentage of Principal Sum shown for that specified body area. If only one of the Insured Person's specified body areas is Severely Burned in an Accident and less than 100% of the surface of that specified body area is Severely Burned, the benefit payable is that same lesser percentage of the Maximum Percentage of Principal Sum shown above for that specified body area. (For example: The Maximum Percentage of Principal Sum shown for the "foot and lower leg below knee joint (right)" specified body area is 27%. If 100% of the surface of that specified body area is Severely Burned, the benefit payable is 100% of 27%, or 27%, of the Principal Sum. If 50% of that surface is Severely Burned, the benefit payable is 50% of 27%, or 13.5%, of the Principal Sum. If 1/3 of that surface is Severely Burned, the benefit payable is 1/3 of 27%, or 9%, of the Principal Sum.)

If more than one of the Insured Person's specified body areas is Severely Burned as a result of the same Accident, the benefit payable is the lesser of: (1) the sum of the benefit amounts calculated separately, according to the above rules, with respect to each such specified body area; or (2) 100% of the Principal Sum.

The determination of whether or not a specified body area is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Physician. The Company has the right, at its own expense, to have the determination verified by a Physician of the Company's choice.

Paralysis Benefit Schedule
All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury**.**

The Accidental Dismemberment Benefit includes Paralysis as a covered loss.

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. Limb means entire arm including its attached hand, or entire leg including its attached foot. As used in the Policy, neither quadriplegia; paraplegia; hemiplegia; uniplegia; nor paralysis includes or means paresis.

Paralysis benefits for more than one type of paralysis may not be combined. If an Insured Person sustains more than one type of paralysis as a result of the same Accident, the only paralysis benefit payable under the Policy will be the largest single paralysis benefit that applies.

Temporary Total Disability Benefit

If Injury to an Insured Person results in Temporary Total Disability within the Disability Commencement Period shown in the Schedule and if the Insured Person has not attained the maximum eligibility age listed on the Schedule on the day the Temporary Total Disability begins, the Company will pay the Temporary Total Disability Benefit specified below, subject to satisfaction of any applicable Waiting Period shown in the Schedule. The Waiting Period starts on the date of the Accident that caused such Injury. Please refer to the Schedule for the description of the applicable Waiting Period. If the Waiting Period is noted as Retroactive, the Temporary Total Disability Benefit shall be payable retroactively from the date the disability began, provided the Insured remains Temporarily Totally Disabled. If the Waiting Period is noted as Non- Retroactive, the Temporary Total Disability Benefit shall be payable beginning on the date only after the applicable Waiting Period has been satisfied and the Insured Person remains Temporarily Totally Disabled. No Temporary Total Disability is payable during the Waiting Period. The Temporary Total Disability Benefit with respect to each week of an Insured Person's Temporary Total Disability during a Single Period of Total Disability is equal to the lesser of:

1. 70% of the Insured Person's Average Weekly Earnings, but no less than the Minimum Weekly Benefit Amount shown in the Schedule; or
2. the Maximum Weekly Benefit Amount shown in the Schedule.

If you have earned income and not reported it to the Federal Government, we will only pay the Minimum Weekly Benefit Amount shown in the Schedule of Benefits

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date the Insured Person is no longer Temporarily Totally Disabled; or
2. the date the Insured Person dies; or
3. the date the Insured Person attains the maximum eligibility age listed on the Schedule; or
4. the first date the Insured Person fails to adhere to the treatment plan the Physician prescribes relative to his or her disabling condition; or
5. the first date on which the Temporary Total Disability is no longer substantiated by objective medical evidence satisfactory to the Company; or
6. the date the Insured Person engages in any activity which results in earned income to him/her; or
7. the date the Maximum Benefit Period shown in the Schedule has been reached.

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 for each day of Temporary Total Disability.

As used above in this Temporary Total Disability Benefit section:

Average Weekly Earnings means the Insured Person's average weekly gross income from Occupational services as defined in this Policy and as reported to the US Internal Revenue Service as Adjusted Gross Income on the Insured Person's US federal tax return, 1099s, W-2s and Schedule C documentation for the tax year immediately preceding the year in which the Temporary Total Disability began.

Note the following adjustments are applicable to Schedule C filings to determine the Adjusted Gross Income for calculating your Temporary Total Disability benefit. Deductible Business Expenses will be subject to a maximum of 65% of Gross Income.

Benefit Week means a period of seven (7) consecutive days. The first Benefit Week during a Period of Temporary Total Disability begins on the first day of Temporary Total Disability after the Waiting Period shown in the Schedule for Temporary Total Disability. For the remainder of the period of Temporary Total Disability, each consecutive seven-day(7-day) period thereafter constitutes a new Benefit Week.

Disability Commencement Period means the period of time, as shown in the Schedule of Benefits, during which the Insured Person must file a Temporary Total Disability claim for the Injury, as measured from the date of the Accident.

Maximum Benefit Period means, with respect to Temporary Total Disability, the maximum period for which benefits shall be payable for a Temporary Total Disability Covered Loss during a Single Period of Total Disability. 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 this 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 the Insured Person is not Temporarily Totally Disabled; and
2. successive periods of Temporary Total Disability, due to the same or related causes, separated by at least 6 consecutive months during which the Insured Person is not Temporarily Totally Disabled.

Temporary Total Disability and **Temporarily Totally Disabled** refer to disability that:

1. prevents an Insured Person from performing the duties of his or her regular, primary occupation; and
2. requires and results in the Insured Person's receiving Continuous Care.

Continuous Care means medical monitoring and/or evaluation of the disabling condition by a Physician on a monthly or more frequent basis. The Insured Person must provide the Company, at least monthly, with proof of continuing Temporary Total Disability.

Continuous Total Disability Benefit

If Injury to an Insured Person, resulting in Temporary Total Disability, such that a Temporary Total Disability Benefit is payable under this Policy, subsequently results in Continuous Total Disability, the Company will pay the Continuous Total Disability Benefit specified below, provided:

1. benefits payable for a Temporary Total Disability Covered Loss ceased solely because the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, but the Insured Person remains disabled; and
2. the Insured Person has not yet reached his/her Social Security Administration Full Retirement Age on the day after the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached; and
3. the Insured Person has presented the Company with written evidence that, no later than the day after the end of the Maximum Benefit Period shown in the Schedule for Temporary Total Disability, an application for Social Security Disability Income (SSDI) was made by or on behalf of the Insured Person. An application for Supplemental Security Income (SSI) is not an application for SSDI and does not satisfy this requirement. The application for SSDI must clearly indicate that the Insured Person's disability is due to Injury caused by the Accident covered under this Policy; and
4. within one year of the expiration of the Maximum Benefit Period in the Schedule of Benefits for Temporary Total Disability , the Insured Person has presented confirmation that the Social Security Administration has granted a SSDI award due to Injuries arising out of the Accident covered hereunder. An award for Supplemental Security Income (SSI) does not satisfy this requirement unless the Insured Person has met all other eligibility requirements for Continuous Total Disability and is denied SSDI solely because he or she has not worked enough qualifying quarters. The Insured Person must comply with all requests from the Company for Social Security Administration documentation confirming SSDI denials are based upon inadequate qualifying work quarters. Failure to comply with requests for confirming documents could result in delays, denials, or suspension of benefits; and
5. an initial Functional Capacity Evaluation (FCE), and all subsequent interim FCEs we may thereafter deem necessary, show that the Insured Person's disability is the result of a covered Injury for which a Temporary Total Disability Benefit was payable under this Policy and is reasonably expected to continue without interruption until the Insured Person dies. All such FCEs must be administered by a licensed Occupational Therapist and confirmed by a licensed Physician, each of whom must meet with our prior approval.

The Continuous Total Disability Benefit with respect to each month of an Insured Person's Continuous Total Disability is equal to four and three-tenths (4.3) times the Weekly Benefit for Temporary Total Disability, less the Insured Person's primary Social Security Disability Award. 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 Temporary Total Disability for each day of Continuous Total Disability.

Benefits payable under the Temporary Total Disability Benefit before the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, will not be considered a Continuous Total Disability Benefit.

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

1. the date the Insured Person is no longer Continuously Totally Disabled as shown by a Functional Capacity Evaluation administered by a licensed Occupational Therapist and confirmed by a licensed Physician, each of whom must meet with our prior approval; the date the Insured Person dies;
2. the date the Insured Person's Social Security Disability Award ceases;
3. the date the Insured Person attains his/her Social Security Administration Full Retirement Age; or
4. the date the Maximum Benefit Period shown in the Schedule for Continuous Total Disability has been reached.

As used in this Continuous Total Disability benefit section:

Benefit Week means a period of seven (7) consecutive days that begins on the day after the Maximum Benefit Period for Temporary Total Disability ends. For the remainder of the period of Continuous Total Disability, each consecutive seven-day(7-day) period thereafter constitutes a new Benefit Week.

Maximum Benefit Period means, with respect to Continuous Total Disability, the maximum period for which benefits shall be payable for a Continuous Total Disability Covered Loss(es). If applicable, the length of the Maximum Benefit Period for Continuous Total Disability is shown in the Schedule.

Continuous Total Disability and **Continuously Totally Disabled** refer to disability that:

1. prevents an Insured Person from performing the duties of all occupations for which he or she is otherwise qualified by reason of education, training or experience; and
2. requires and results in the Insured Person's receiving Continuous Care.

Continuous Care means medical monitoring and/or evaluation of the disabling condition by a Physician on a monthly or more frequent basis. The Insured Person must provide the Company, at least quarterly, with proof of continuing Continuous Total Disability.

Other terms used in this Continuous Total Disability benefit, but which refer to Temporary Total Disability and are defined in the Temporary Total Disability benefit section, are to be interpreted as defined in that section.

Accident Medical Expense Benefit

If an Insured Person suffers an Occupational Injury that requires him or her to be treated by a Physician within the Accident Medical Expense Benefit Commencement Period, the Company 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 Accident, subject to any applicable Deductible Amount. The Maximum Benefit 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 separately for each Accident from the Usual and Customary Charges for Medically Necessary Covered Accident Medical Services incurred due to Injuries sustained by the Insured Person in that Accident.

As used in this Accident Medical Expense Benefit provision:

Accident Medical Expense Benefit Commencement Period means the period of time, as shown in the Schedule of Benefits, during which the Insured Person must file a Medical Expense Benefit claim for the Injury, as measured from the date of the Accident.

Ambulatory Medical Center means a licensed public establishment with an organized staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing surgical procedures. Such establishment must provide continuous Physician and registered nursing (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital, a Physician's office, or a clinic.

Covered Accident Medical Service(s) means one or more of any of the following 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, a Registered Nurse, LPNs, BSNs, nurse practitioners, PAs, and other kinds of licensed nursing personnel;
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy, Occupational therapy, and chiropractic care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule;
9. rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances; or
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription; or
12. The following specific Dental Services, required to treat a dental Injury as a result of an Occupational Accident which happens while covered:
    a) Appliances and splints placed on or attached to sound natural teeth
    b) Full or partial dentures.
    c) Fixed bridgework if needed because of Accidental Injury to sound natural teeth
    d) Prompt repair to sound natural teeth if needed because of Accidental Injury to those teeth.

Custodial Services means any of the following kinds of services which are provided to care for an Insured Person's physical well-being, but are not intended primarily as medical treatment for a specific Injury. Custodial Services include, but shall not be limited to, services:

1. related to watching or protecting the Insured Person;
2. related to performing or assisting the Insured Person 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.

Deductible (Applies to Accident Medical Expense Benefits only)
We will pay covered Accident Medical Expense Benefits only in excess of the applicable Deductible Amounts shown in the Schedule. Each applicable Deductible Amount shown in the Schedule applies separately to each Covered Loss and to each Insured Person sustaining a particular type of covered Loss. For Accidents causing more than one Covered Loss, each applicable Deductible Amount applies separately.

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 also be used in the treatment of Injury or for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Hospital means a facility that:

1. is operated according to law for the care and treatment of injured people;
2. has organized facilities for diagnosis and surgery on its premises, or in facilities available to it on a prearranged basis;
3. has 24-hour nursing service by registered nurses (RNs), on duty or on call; and
4. is supervised by one or more Physicians.

A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital in which a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes; or (3) any military or veterans' hospital or soldiers' or sailors' home or any hospital contracted for or operated by any government or government agency for the treatment of members or ex-members of the armed forces.

Maximum Benefit Period means, with respect to Accident Medical Expense, the maximum period for which benefits shall 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.

Medically Necessary means that a Covered Accident Medical Service: (1) is essential for diagnosis, treatment or care of the Occupational 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 either by a Physician or under his or her care, supervision or order.

Personal Comfort or Convenience Item(s) means those items that are not Medically Necessary for the care and treatment of the Insured Person's Occupational 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.

Sound Natural Teeth means natural teeth that either are unaltered or are 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: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (or, for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, one that does not exceed the Hospital's most common charge for semi- private room and board); and (3) does not include charges that would not have been made if no insurance existed.

In addition to the Exclusions in Section VI of this Policy, Usual and Customary Charges for Covered Accident Medical Services do not include, and benefits are not payable with respect to, any expense for or resulting from:

1. 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;
2. new or repair or replacement of, dentures, bridges, dental implants, dental bands or braces, or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums; unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
3. new eyeglasses or contact lenses or eye examinations related to the correction of vision or to the fitting of glasses or contact lenses, unless Occupational Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;
4. new hearing aids or hearing examinations, unless Injury has caused impairment of hearing, or repair or replacement of existing hearing aids, unless for the purpose of modifying the item because Occupational Injury has caused further impairment of hearing;
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense Benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense Benefit in lieu of such rental expense);
6. Custodial Services; or
7. Personal Comfort or Convenience Items.

NON-OCCUPATIONAL COVERAGE

Non-Occupational Coverage. Refer to the Schedule of Benefits if coverage has been extended for Non-Occupational Injury and Non-Occupational Accidents. Only those benefits listed in the Schedule under Non-Occupational Benefits shall be payable, subject to the limitations shown therein.

Non-Occupational means, with respect to an activity, Accident, incident, circumstance or condition involving an Insured Person that the activity, Accident, incident, circumstance or condition is not proximately caused by the Insured Person's performing Occupational Services.

Non-Occupational Injury means physical Injury caused by a Non-Occupational Accident occurring while this Policy is in force as to the person whose Injury is the basis of claim and resulting directly and independently of all other causes in a Covered Loss.
All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

SECTION V

Limits of Liability

The limits of insurance shown in the Schedule and the rules below fix the most we will pay, regardless of the number of Insured Persons, Accidents, or persons applying for benefits.

Combined Single Limit. The Combined Single Limit stated in the Schedule is the most we will pay for the sum of any and all benefits payable under this Policy with respect to any one Insured Person, on account of any and all Injury sustained by that Insured Person as the result of any one Accident.

Aggregate Limit. The Certificate Aggregate Limit stated in the Schedule is the most we will pay for the sum of any and all benefits payable under the Policy on account of all Injury sustained by all Insured Persons(s) as the result of any one Accident.

SECTION VI

EXCLUSIONS

This Policy does not cover any Injury, Accident, covered expense, or Covered Loss caused in whole or in part by, or resulting in whole or in part from, any of the following:

1. an Insured Person's suicide or any attempted suicide; suicidal gesture; intentionally self- inflicted Injury, or attempted intentionally self-inflicted Injury;
2. sickness, disease or infection of any kind, except bacterial infection due to a cut or wound, or botulism or ptomaine poisoning, caused directly by an Occupational Accident;
3. any Pre-Existing Condition, unless the Insured Person has been continuously covered under this Policy (or a substantially identical Policy issued by the Company or another insurer, of which this Policy is a renewal) for twelve consecutive months;
4. Occupational Cumulative Trauma, unless (and then only to the extent that) such coverage has been specifically added to this Policy;
5. Occupational Disease, unless (and then only to the extent that) such coverage has been specifically added to this Policy;
6. hernia of any kind, unless (and then only to the extent that) such coverage has been specifically added to this Policy;
7. hemorrhoids of any kind, unless (and then only to the extent that) such coverage has been specifically added to this Policy;
8. performing, learning to perform, or instructing others to perform as a master or crew member of any vessel while covered under the Jones Act or the United States Longshoremen's and Harbor Workers' Compensation Act or any amendment of that Act, or any similar state or federal law;
9. declared or undeclared war, or any act of declared or undeclared war;
10. full-time active duty in the armed forces of any country or international authority, except the part-time National Guard or normal organized reserve corps duty consisting of one weekend per month and 2 consecutive weeks per year;
11. any Injury for which the Insured Person is entitled to benefits pursuant to any workers' compensation law or other similar legislation;
12. Employers' Liability under any Workers' Compensation statute;
13. the Insured Person's being under the influence of any drug or intoxicant, unless taken at the direction of his or her Physician; or
14. the Insured Person's commission of, or attempt to commit, any felony; or
15. travel or flight in or on (including getting in or out of, or on or off of) any type of aircraft, if the Insured Person is:
    a) riding as a passenger in any aircraft not designed and licensed for the transportation of passengers; or
    b) performing, learning to perform, or instructing others to perform as a pilot or crew member of any aircraft; or
    c) riding as a passenger in any aircraft owned, leased or operated by this Policyholder or Contractee; or
16. any strike, boycott, or stop-work action, whether or not the Insured Person participates in such strike, boycott, or stop-work action.

SECTION VII

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be received by the Company within 20 days after an Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice must be given by or on behalf of the claimant to the Company at Great American Insurance Company, ON Demand Claims, 301 E. 4th St., 22nd Floor; Cincinnati, OH 45202, 1-833-444-0161, with information sufficient to identify the Insured Person.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within fifteen (15) days after the claimant has provided the complete Notice of Claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include contact information for the person making the Notice of Claim, the date, time and location of the Accident, this Policyholder or Contractee's name, the Certificateholder's name, the Insured Person's name and this Policy number.

Cooperation. In connection with the investigation of any claim made by, or the continuing disability, of an Insured Person, the Insured Person shall cooperate and, if requested to do so, provide the Company with a written or recorded statement concerning the Accident, the Injury, and all circumstances of the claim made and the continuing disability and submit to an examination under oath.

Proof of Covered Loss. Written proof of a Covered Loss must be furnished to the company within ninety (90) days after the date of the Covered Loss. If the Covered Loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility and of the Covered Loss must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proofs within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished 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 for the Covered Loss.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. Upon receipt of due written proof of loss, payments for all other losses will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments required under this Policy have been made, then any remaining amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. If any payee is a minor or 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 the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's sole judgment, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

The Company may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. Such request must be made no later than the time proof of loss is filed. Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under this Policy, other than for loss for which this Policy provides for periodic payments, will be paid within sixty (60) days after the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Commutation of Losses. It is agreed that, at the Company's sole option, at any time later than two years from the date of any Accident resulting in a claim under this Policy, the Company may advise the Insured Person of its desire to be released from liability with respect to any such claim. In that event, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and the payment by the Company of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim.

Sunset. No claim by any Insured Person or beneficiary will be considered valid or collectible under this Policy unless full details of such claim have been presented to the Company within two (2) years from the date of the Accident which gives rise to such claim.

Appeals Process. If an Insured Person disputes a denial of benefits, he or she may request, in writing and within 30 days after the denial, an Independent Physician's examination. The Company, at its own expense, shall provide the Insured Person with a list of three (3) Independent Physicians and the Insured shall have the right to choose the Independent Physician who will conduct the examination. If the Insured Person fails to make a selection within fifteen(15) calendar days after the date the list is provided, the Company shall have the right to either choose the Independent Physician to conduct the examination or determine eligibility of benefits based upon the results of a previous examination by an Independent Physician. Both parties agree to rely upon the results of the Independent Physician's objective examination. The Company has the right to suspend benefits if the Insured Person fails to make or attend appointments with the Independent Physician or to submit to required objective examinations.

Utilization Review. A claim may be subject to utilization review in an effort to speed the Insured Person's recovery, restoration of pre-Injury health, and ultimate return to work.

SECTION VIII

GENERAL PROVISIONS

Entire Contract; Changes. This Policy, together with any Schedules, riders, endorsements, amendments, applications, and enrollment forms, if any, make up the entire contract between this Policyholder and the Company. In the absence of fraud, all statements made by this Policyholder or any Insured Person will be considered representations and not warranties. In most jurisdictions, committing fraud or providing material misrepresentations in order to secure insurance or in making a claim, can void coverage and may result in criminal prosecution. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or his or her beneficiary or personal representative.

No change in this Policy will be valid until approved by an officer of the Company. Such approval must be noted on or attached to this Policy in writing. No agent may change this Policy or waive any of its provisions.

Extraterritorial Coverage. Any Covered Medical Services received outside of the United States for a covered Injury will be subject to prior approval by the Company. The Company will reimburse the Insured Person or their representative for payments made for Covered Medical services, subject to this Policy's terms and conditions as if the Covered Medical Services had been received within the United States. Adjustments for the exchange rate between the US Dollar and the respective foreign currency will be as of the date of treatment. Covered Medical Services will also be subject to Usual and Customary charge adjustments based upon similar treatment within the United States.

Incontestability. Except as to nonpayment of premiums, the validity of this Policy will not be contested after it has been in force for two years from this Policy Effective Date.

Beneficiary Designation and Change. The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured as shown on this Policyholder's records kept on this Policy.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advance by the Company, this Policyholder with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, this Policyholder, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

Except with regard to the Survivor's Benefit described in Section IV of this Policy, if applicable, in the event that there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: the Insured's: (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

Physical Examination and Autopsy. The Company has the right, at its own expense, to examine the person of any Insured Person whose Injury is the basis of a claim, when and as often as may be reasonably required during the pendency of the claim or while receiving periodic benefits. In the case of a disability claim, the Company also has the right to require the Insured Person, at the Company's expense, to submit to an Occupational Assessment and/or a Functional Capacity Examination. The Company may also require an autopsy, at its own expense, of the remains of any Insured Person where it is not prohibited by law.

Legal Actions. No legal action for a claim can be brought against the Company until 60 days after the Company's receipt of proof of loss. No legal action for a claim can be brought against the Company more than three years after the time for giving proof of loss.

Right to Examine Coverage. The coverage provided under this Policy may be terminated for any reason by the Insured Person within thirty (30) days after initial enrollment. Written notice of termination should be forwarded by mail or in person to the Company at its Home Office. Any premium paid will be refunded and the coverage will be treated as if it had never been issued.

Noncompliance With Policy Requirements. No express or implied waiver by the Company of any requirement(s) of this Policy will constitute a continuing waiver of such requirement(s). Any failure by the Company to insist upon compliance with any Policy provision(s) will not operate as a waiver or amendment of that provision.

Conformity With State Statutes. Any provision of this Policy which, on the Policy's Effective Date, is in conflict with the law of the state in which this Policy was delivered is hereby amended to conform to the minimum mandatory requirements of such law.

Clerical Error. Clerical error, whether by this Policyholder, the Certificateholder, the Insurance Agency listed on the Schedule of Benefits, or the Company, in keeping records pertaining to this Policy, will not: (1) invalidate coverage otherwise validly in force; or (2) continue coverage otherwise validly terminated.

Data Required. This Policyholder and the Contractee must maintain adequate records acceptable to the Company, and provide any information required by the Company relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Audit. The Company will have the right to inspect and audit, at any reasonable time, all records and procedures of this Policyholder and the Contractee that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Subrogation. To the extent the Company makes a payment under this Policy and the person to whom or for whose benefit payment has been made has any right to recover from anyone liable for the Injury or death, the Company may assume the rights of the Insured and/or Designated Beneficiary/Survivor. The Company shall be reimbursed for any payments made to or on behalf of the Insured Person and/or Designated Beneficiary/Survivor, regardless of whether or not the Insured Person or person to whom payment has been made has been made whole. The Insured Person and/or his or her Designated Beneficiary/Survivor shall do everything necessary to transfer those rights to us, shall do nothing to prejudice those rights and agrees to assist the Company in preserving its subrogation and reimbursement rights.
The Insured Person, Designated Beneficiary or Survivor must reimburse the Company for any payments the Company makes under this Policy, to the extent that Insured Person, Designated Beneficiary or Survivor receives payment from any party for the same Injury, Covered Loss, or death.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to the Company herein, or which the Company may have by operation of law, when payments have been made by the Company 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 this Policy, the Company shall have the right to recover such excess payment from any one or more of the following: any person to whom such payments were made (e.g., medical providers, etc.), the Insured Person, any beneficiary, any insurance company, or any other organization(s) which received, or should have received, the payment.

Conditional Claim Payment. If an Insured Person suffers Covered Loss(es) as the result of Injuries for which, in the opinion of the Company, a third party may be liable, the Company will pay the amount of benefits otherwise payable under this Policy. However, if the Insured Person receives, collects, or recovers damages or other payment from the third party, the Insured Person agrees to refund to the Company the lesser of: (1) the amount actually paid by the Company 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 the Insured Person does not receive payment from the third party for such Covered Loss(es), the Company reserves the right to subrogate under the Subrogation clause of this Policy.

The above amount shall be paid to the Company at the time such third party's liability is determined and satisfied, whether such damages and/or liability has been determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

Offset. The Company 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 this Policyholder to the Company against any balance or balances, whether on account of losses or otherwise, due from the Company to this Policyholder.

Other Insurance. If the Insured Person incurs losses for which benefits are payable under this Policy and any one or more similar policies issued by the Company or one of its affiliates, the coverage under this Policy shall be in excess of such other insurance, and will not contribute to such a loss with such other insurance. This condition does not apply to: (1) the Accident Medical Expense benefit described in Section IV of this Policy or (2) other insurance which the
Insured Person has procured and which was issued expressly to apply in excess of the coverage under this Policy.

Plan and Exposure Changes. The Contractee must notify the Company of any of this Policyholder's subsidiaries or affiliated companies, including any newly acquired or newly formed subsidiaries or affiliated companies, that are to be included as part of the Contractee under this Policy. Such notice must be received by the Company within thirty (30) days of the acquisition or formation of each such subsidiary or affiliated company. If such notice is not provided, the subsidiary, affiliate, or other entity will not be considered a part of the Contractee, or of a covered affiliate or subsidiary, and no person related to such subsidiary, affiliate, or other entity will be considered as an Insured Person of the Contractee, or of a covered affiliate or subsidiary for purposes of this Policy, until the date such notice is provided. The Company has the right to adjust the premium for this Policy based on any change in exposure, whether as a result of such notice or otherwise.

Non-Duplication of Workers' Compensation Benefits. No direct benefits are payable under this Policy to or on behalf of any Insured, Authorized Passenger or Designated Beneficiary who is covered by any Workers Compensation, Employers Liability, Occupational Disease or similar law or Policy. In the event duplicate benefits are paid under this Policy and under any Workers Compensation, Employers Liability, Occupational Disease or similar law or Policy for the same or substantially the same Injury, the Insured, Authorized Passenger or Designated Beneficiary must immediately reimburse the Company for all of the benefits that were paid under this Policy.

Excess Benefits. When an Insured Person has any Injury or loss to which both Accident Medical Expense coverage under this Policy and health care coverage under one or more other policies or plans applies, then the Accident Medical Expense benefit under this Policy shall apply only in excess of the benefits of the other Policy or plan as described below, unless **both:** (1) the
other Policy or plan has coordination or excess benefits rules that require its benefits to be determined in excess of the benefits of this Policy; **and** (2) this Policy has covered the Insured Person longer than the other Policy or plan has. When the Accident Medical Expense benefit under this Policy is excess, such benefits for any Allowable Expenses will be reduced when the sum of:

1. the amount of the Accident Medical Expense Benefit Deductible, if any, that would be applied to those Allowable Expenses under this Policy in the absence of this provision, **plus**
2. the benefits that would be payable for those Allowable Expenses under this Policy in the absence of this provision, **plus**
3. the benefits that would be payable for those Allowable Expenses under the other Policy or plan in the absence of a coordination of benefits or excess benefits provision, exceeds the amount of those Allowable Expenses. In that case, first this Policy's Accident Medical Expense benefits, and next (if necessary) the applied amount of this Policy's deductible, if any, will be reduced so that this Policy's benefits (net of any applied deductible amount) and the other Policy's or plan's benefits do not total more than the amount of those Allowable Expenses.

Right to Receive and Release Needed Information. The Company has the right to decide in its sole judgment what facts it needs to administer this Policy. It may get needed facts from, or give them to, any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts the Company deems necessary to determine coverage under this Policy or to determine the correct payment of a claim.

Right of Recovery. If a payment made under another policy or plan includes an amount that should have been paid under this Policy, the Company may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy and the Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Company is more than it should have paid under this Policy, it may recover the excess from any person(s) to or for whom it has overpaid, including insurance companies or other organizations.

Allowable Expense means the usual and customary charge for a medically necessary service or item of expense for health care when the item of expense is covered at least in part by this Policy and is also covered at least in part by one or more other policies or plans covering the Insured Person. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid, as if its reasonable cash value had been charged as the cost for the service and such expense would have been covered at least in part by this Policy.

As used above in this Section, **plan** includes any of the following group, group-type (such as, but not limited to, franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies, (2) subscriber contracts, (3) uninsured arrangements, (4) labor- management Trustee, union welfare, employer organization, or employee benefit organization plans, (5) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans, (6) medical benefits coverage in automobile 'no-fault' and traditional automobile "fault" type contracts, and (7) coverage under any governmental plan (including provincial plans) or coverage required or provided by law; but **plan** does not include: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or
(b) this Policy, or (c) a plan or law that, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan.

Certificates of Insurance. The Company will issue to this Policyholder certificates of insurance for delivery to each Insured, where required by law. Certificates will list the benefits, conditions and limits of this Policy and to whom benefits will be paid.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

CERTIFICATE OF INSURANCE
INDEPENDENT CONTRACTORS OCCUPATIONAL ACCIDENT INSURANCE

We have issued the Group Policy referenced on the Schedule of Benefits (called the Policy) to the Policyholder. The Policy provides disability income benefits.

If the terms of this certificate and the Policy differ, the Policy will govern.

This is your certificate of insurance. It includes the Policy and all applicable benefit riders and schedules issued to the Policyholder. It replaces any prior certificate of insurance issued to you.

The Policy and this certificate may be changed or canceled at any time according to the terms and conditions of the Policy.

The Company agrees to insure Certificate holder (herein called Insured) against loss covered by this Policy, subject to its provisions, limitations and exclusion. The persons eligible to be Insured Persons are all persons scheduled in the Description of Eligible Persons section of the Schedule of Benefits.

This Certificate is issued in consideration of the payment of the required premium when due and the statements set forth in the signed individual enrollment forms.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

IMPORTANT NOTICE

THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE. THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

This Policy is governed by the laws of the state in which it is delivered.

PLEASE READ THIS POLICY CAREFULLY

Non-Participating Insurance

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

OCCUPATIONAL DISEASE COVERAGE RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy's Schedule of Benefits and applies with respect to Occupational Disease, provided the Insured Person's last day of last exposure to the environmental or physical hazards causing the Occupational Disease occurs during the Policy Period. This Rider is subject to all of the provisions, limitations, and exclusions of the Policy except as this Rider specifically modifies them.

Occupational Disease Coverage. Exclusion 5 in Section VI of the Policy is waived for a Covered Loss with respect to the following benefit(s) only: Accidental Medical Expense and Temporary Total Disability.

Accidental Medical Expense and Temporary Total Disability benefits shall be payable for the Insured Person's Occupational Disease, subject to the following:

1. any reference in the Policy to the date of an Injury, Accident or Occupational Accident is, with respect to Occupational Disease, deemed to refer to the date on which the Insured Person was last exposed to the environmental or physical hazards causing the Occupational Disease;

2. any and all Occupational Diseases suffered by any one Insured Person due to exposure to environmental or physical hazards during the course of his or her Occupational activities are deemed to be a single Occupational Disease; and

3. with respect to the Accident Medical Expense Benefit, benefits payable for or in connection with the Insured Person's Occupational Disease, subject to the Accident Medical Expense Deductible Amount, if any, shall not exceed the applicable Hernia or Hemorrhoids or Occupational Cumulative Trauma or Occupational Disease Lifetime Maximum Benefit Amount shown in the Schedule

4. with respect to the Temporary Total Disability Benefit, the period for which such indemnity shall be payable for all periods of disability, subject to the Temporary Total Disability Benefit Waiting Period, shall not exceed the applicable Hernia or Hemorrhoids or Occupational Cumulative Trauma or Occupational Disease Lifetime Maximum Benefit Period or Amount shown in the Schedule.

5. the maximum combined benefit payable under the Policy with respect to all Insured Persons suffering Occupational Disease due to exposure to environmental or physical hazards during the course of their Occupational activities will not exceed the applicable Limit(s) of Liability shown in the Schedule, regardless of the number of Insured Persons or the number or type of Covered Losses.

6. such Occupational Disease is diagnosed by a Physician and is generally accepted by the National centers for Disease control to be a disease caused by such hazards,

7. exposure to such hazards is not an Accident but is caused or aggravated by the conditions under which the Insured Person performs Occupational Services,

8. such exposure results directly and independently of all other causes in a Covered Loss.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

GENERAL CHANGE FORM

ENDORSEMENT 1 EFFECTIVE 04/01/2023

It is hereby understood and agreed that Policy Form F.32457 (8-12) has been amended as follows for **Plan C:**

1. It is hereby understood and agreed that the **Eligibility** shall be extended for **Plan C** to **Independent Contractors** in the state of California over age 75 and who were authorized by the **Company.** A Part Time **Independent Contractor** will only be covered for an **Accident** which occurs while the **Insured Person** is working under **Covered Contract** with the contract company designated at the time of enrollment.

2. **SECTION 1-GENERAL DEFINITIONS** has been revised to delete **Covered Contract** in its entirety and replaced with the following:

   Covered Contract means a written agreement between the **Insured Person and** the **Policyholder, Contractee**, or **Network Company** with whom he or she has an agreement to provide **On Demand Platform Service(s**).

3. **SECTION 1-GENERAL DEFINITIONS** has been revised to delete **Independent Contractor** in its entirety and replaced with the following:

   Independent Contractor and **Insured Person** means a person who:
   1. is under a written **Covered Contract** with the **Policyholder, Contractee**, or **Network Company** to provide **On Demand Platform Service(s)** through the **Policyholder, Contractee,** or **Network Company;**
   2. is responsible for abiding by the terms and conditions stated in the **Covered Contract**;
   3. is responsible for performing the **On Demand Platform Service(s)** within the course and scope of his or her obligations as stated in the **Covered Contract**;
   4. is classified and treated as an **Independent Contractor** by the **Policyholder, Contractee**, or **Network Company** and not an employee, for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, or unemployment insurance or for any other purpose;
   5. is not an employee of the **Policyholder, Contractee**, or **Network Company**;
   6. receives or is scheduled to receive an IRS Form 1099 for federal income tax reporting purposes, not a W-2, unless the **Independent Contractor** has an ownership interest in a business entity and receives, for federal income tax purposes, a tax reporting form from such business entity, as an employee, shareholder, member or partner of such business entity;
   7. is authorized to use a motorized vehicle if a motorized vehicle needs to be used to provide the **On Demand Platform Service(s);** and
   8. holds and maintains a valid and current driver's license with the appropriate level of certification to operate the motorized vehicle if a motorized vehicle is being used to provide **On Demand Platform Service(s).**

   If an **Independent Contractor** is covered under more than one policy issued by Us for the same Injury, only one policy will pay benefits, the policy with the largest benefit.

4. **GENERAL DEFINITIONS** has been revised to delete **Insured Person** in its entirety and replaced with the following:

   Insured Person means a person who is a member of an eligible class as described in the Classes of Eligible Persons section of the **Schedule of Benefits**, who is performing services within the course of their **Covered Contract** and who has paid the required premium when due. **Insured Person** is also an **Independent Contractor**.

5. **SECTION 1-GENERAL DEFINITIONS** has been revised to delete **Occupational** in its entirety and replaced with the following:

   Occupational means, with respect to an activity, **Accident**, incident, circumstance, or condition involving an I**nsured Person**, that the activity, Accident, incident, circumstance, or condition occurs or arises out of or in the course of the **Insured Person** performing **Occupational** services within the course and scope of contractual obligations for the **Policyholder or Contractee** and while under **Covered Contract**. Occupational encompasses the period of time when the **Insured Person** is: (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) returning to a terminal or home after delivering a load, which ever occurs first; (6) waiting for a load if the **Insured Person** is not at home; or (7) required to perform services, including installing or setting up, in

accordance with a delivery service agreement or other similar agreement. **Occupational** does not encompass any personal deviations or personal business use while performing contractual obligations. Any such personal deviations or personal business use after an **Insured Person** completes the last delivery of the day terminates coverage for that day.

6. **SECTION 1-GENERAL DEFINITIONS** has been revised to include the following definitions:

Commencement Period means the period of time, as shown in the Schedule of Benefits, during which the **Insured Person** must file a claim for the Injury, as measured from the date of the accident.

Network Company means a business entity that is a delivery network company ("DNC") and/or a transportation network company ("TNC") that maintains a Platform that facilities **On-Demand Platform Service(s).**

Online means the time when an Insured Person is utilizing a Network Company's online-enabled application or Platform and can receive requests for On Demand Platform Service(s) or is engaged in performing On Demand Platform Service(s).

Personal Deviation(s) means non-business activities and/or travel of a personal nature, undertaken during the performance of **On Demand Platform Service(s)** that are unrelated to the course and scope of the **Insured Person's** contractual obligations.

Platform(s) means any online-enabled application, software, website or system operated by an organization, including but not limited to, a corporation, limited liability company, partnership, sole proprietor or any other entity that facilitates the provision of **On-Demand Platform Service(s)** for **Independent Contractors**.

On Demand Platform Service(s) means:

1. the **Independent Contractor** is **Online** utilizing the Network Company's Platform(s) and can seek/await requests to fulfil their contractual obligations of service; or
2. **Independent Contractor** accepts a request to perform On-Demand services through the **Platform(s),** and is enroute to the first requested pick-up location;
3. continuing while the Independent Contractor procures, transports goods, and or assembles goods and
4. ending at the later of:
5. when the goods have been delivered and or assembled and the **Independent Contractor** is no longer on the delivery premises; or
6. when the **Platform Service** is cancelled (and such cancellation is notified to the **Independent Contractor**) with no further action required by the **Independent Contractor**; or
7. any time spent on service where the **Independent Contractor** abandons performance of the service prior to completion; or
8. when the goods have been returned to the merchant by the **Independent Contractor** due to the cancellation of the **On-Demand Service** which required further action by the **Independent Contractor**.

7. **SECTION IV- BENEFITS Temporary Total Disability** has been revised as follows by removing Item #1 reference to 70% of the Insured Persons Average Weekly Earnings from the first paragraph and replacing it with:

1. 66% of the Insured Person's Average Weekly Earnings, but no less than the Minimum Weekly Benefit Amount shown in the Schedule.

8. **SECTION IV-BENEFITS Temporary Total Disability** has been revised to remove the definition **Average Weekly Earnings** in its entirety and replaced with the following:

Average Weekly Earning means the **Insured Person** total earnings from all **Network** Companies as recorded by **Network** Companies online application or Platform from where the **Insured Person** accepts a **Covered Contract** during the twenty-eight (28) days prior to the covered accident divided by four. **Average Weekly Earnings** does not include gratuities, platform or administrative fees, tolls, cleaning fees, airport fees, or other customer pass-throughs.

Insured Person is responsible to provide to Us with a detailed statement from the **Network** Companies indicating total earnings during the twenty-eight (28) days prior to the covered accident.

9. **SECTION VI-EXCLUSIONS** has been revised to include the following exclusion:

17. The **Company** will not cover any **Accident** that occurs while Online and outside of performing **On Demand Platform Service(s)** for the **Network Company** where the injured **Insured Person** is engaged in **On Demand Platform Service(s)** for one or more other **Network Company** Platform(s), or where the **Insured Person** is engaged in **Personal Deviations**.

18. The policy excludes all coverages for any Helper that the Independent Contractor authorizes.

8. **SECTION VIII-GENERAL PROVISIONS** has been revised to delete **Subrogation** in its' entirety and replace with the following:

Subrogation. To the extent the **Company** makes a payment under this **Policy** and the person to whom or for whose benefit payment has been made has any right to recover from anyone liable for the Injury or death, the **Company** may assume the rights of the Insured and/or Designated Beneficiary/Survivor. The **Company** shall be reimbursed for any payments made to or on behalf of the **Insured Person** and/or Designated Beneficiary/Survivor, regardless of whether or not the **Insured Person** or person to whom payment has been made has been made whole. The **Insured Person** and/or his or her Designated Beneficiary/Survivor shall do everything necessary to transfer those rights to us, shall do nothing to prejudice those rights and agrees to assist the **Company** in preserving its subrogation and reimbursement rights.

If an accident is covered by occupational accident insurance or accidental death benefits maintained by more than one **Network Company**, the insurer of the **Network Company** against whom a claim is filed has the right to recover the contribution for the pro-rata share of coverage attributable to one or more other **Network Companies** up to the coverage and limits as noted in the Schedule of Benefits for Accident Medical Expenses and Accidental Death benefits.

In Witness Whereof, **We** have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

President **Secretary**

Exhibit A
California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. I f this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209
(323) 782-0182
or
Consumer Service Division California
Department of Insurance 300 South Spring
Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

Coverage

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of

insured persons are protected as well, even i f they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self- funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion o f a policy which is not guaranteed by the insurer or f o r which the individual has a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate; rating credits.

Limits on Amounts of Coverage

The Act limits the Association to pay benefits as follows:

Life and Annuity Benefits

* 80% of what the life insurance company would owe under a life policy or annuity contract up to * $100,000 in cash surrender values, * $100,000 in present value of annuities, or * $300,000 in life insurance death benefits.* A maximum of $300,000 for any one insured life no matter how many policies and contracts there were with the same company, even i f the policies provided different types of coverages.

Health Benefits

* A maximum of $527,507 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

Premium Surcharge

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

Exhibit B
Notice of Non-Coverage California Life and Health Insurance Guarantee Association Act

These types of polices are NOT covered by The California Life and Health Insurance Guarantee Association

Exclusions from Coverage

The following are not covered by the California Life and Health Insurance Guarantee Association:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by individuals and which guarantee rights to group contract holders, not individuals;

- Employer and association plans, to the extent they are self- funded or uninsured;

- Synthetic guaranteed interest contracts;

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- Any policy of reinsurance unless an assumption certificate was issued;

- Interest rate yields that exceed an average rate;

- Any portion of a contract that provides dividends or experience rating credits.
  A determination as to whether an insurance contract is covered under the Guarantee Association or whether an annuity contract is allocated or unallocated must initially be made by the insurer based on its knowledge of the specific contract offered.

  Also, you are not protected by this Association if:

- The insurer was not authorized to do business in this state when it issued the policy or contract;

- The policy is issued by a health care service plan (HMO), Blue Cross, Blue Shield; a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

- You are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

If you have questions concerning this Notice, you may contact

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209

(323) 782-0182
or
Consumer Service Division California
Department of Insurance 300 South Spring
Street
Los Angeles, CA 90013

(800) 927-4357 or (213) 897-8921
Questions as to specific policies or annuities should be directed to the insurance company offering the product.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF CALIFORNIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations, and exclusions of the Policy except as this Rider specifically modifies them.

1. The following is added to Section VII Claims Provisions:

   (a) If the Policy includes any periodic payment which depends on continuing loss, written proof of loss must be given to Us within 90 days after the end of the period for which the Company is liable.

   (b) Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the extent benefits for the same expenses are paid to the provider.

2. The following is added to the Accident Medical Expense Benefit:

   (a) Benefits for services given by the following licensed or certified provider acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).

   (b) Speech Therapist's Services

   Benefits for services given by a licensed or certified speech therapist acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).
   Services of a speech therapist including restorative or rehabilitative speech therapy.
   These services must be in connection with speech loss, impairment, or defect due to a covered Occupational Injury.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

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TRADE OR ECONOMIC SANCTIONS EXCLUSION

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

GREAT AMERICAN INSURANCE GROUP
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301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

APPLICATION FOR GROUP INSURANCE

To: Great American Insurance Company
301 E. 4th Street
Cincinnati, OH 45202-4201

Policyholder: Association for Delivery Drivers

Address: P.O. Box 123
Gaylordsville, CT 06755

The Policyholder applies for a Group Policy to cover Eligible Persons as stated in the Schedule of Benefits.

The Insurance Company identifies the policy as Policy Number OA3735899.

The policy includes any and all riders attached to it. The Policyholder has approved it and accepts its terms.

The policy will take effect on 04/01/2023.

Premium payments are required monthly.

Any earlier application is replaced by this application.

Dated at _____

20 _____

By: _____
Policyholder's Signature

Countersigned by
(where required)_____

Resident Licensed Agent

GREAT AMERICAN INSURANCE GROUP

Property and Casualty
Privacy Notice and Notice of Insurance Information Practices

FACTS	WHAT DOES GREAT AMERICAN INSURANCE GROUP–PROPERTY AND CASUALTY ("GREAT AMERICAN") DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security Number, date of birth, income; • Policy coverage, premiums, account balances, payment and claim history; • Credit history, driving record, medical and employment information. When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to operate their business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Great American chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Great American share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	No	We do not share
For our nonaffiliates to market to you	No	We do not share

Questions?	Call 1-800-545-4269 or go to http://www.greatamericaninsurancegroup.com.

Who we are	
Who is providing this notice?	This notice is provided by certain companies that make up Great American. These companies are listed below.

What we do	
How does Great American protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also limit access to your information to those who need it to do their jobs.
How does Great American collect my personal information?	We collect personal information about you, for example, when you • Apply for insurance • Give us your contact information • Pay your insurance premiums • File an insurance claim • Tell us who receives the money • Visit our website or email us. We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal laws give you the right to limit only: • Sharing for affiliates' everyday business purposes—information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Our affiliates include: • Financial companies with a common Great American name; • Financial companies, such as MidContinent Casualty Company, Republic Indemnity Company of America, Summit Consulting LLC, National Interstate Insurance Company, or Premier Lease and Loan Services Insurance Agency, Inc. • Others, such as American Financial Group, Inc.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. Great American does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include insurance agents or other insurance licensees.

Other important information

We do not disclose your health information with third parties, unless authorized by you or as allowed or required by law. We may disclose your information, as permitted by law, to underwrite or administer your policy, claim or account.

We may disclose your information to conduct research, so long as no individual data may be identified in the research study report.

You may review and correct information that we collect about you. To access your information please send a signed, written request to P&C Legal at Great American Insurance Company, 301 East Fourth Street, Cincinnati, Ohio 45202-4269; or by email to clegal@gaig.com. Please include your full name, address, telephone number, and policy number in your letter. We may request other information to validate your identity, such as a copy of your driver's license or other valid photo identification. If you believe any of your information is incomplete or incorrect, please write to us and explain what data you believe needs correcting. We will review your information. If we agree, we will correct our records. If we do not agree, you may file a written statement of dispute with us. Upon your request, we also may provide you with more information regarding the disclosure of your information.

Great American Insurance Company
Great American Alliance Insurance Company
Great American Assurance Company
Great American Casualty Insurance Company
Great American Contemporary Insurance Company
Great American E&S Insurance Company
Great American Fidelity Insurance Company
Great American Insurance Company of New York
Great American Protection Insurance Company
Great American Security Insurance Company
Great American Spirit Insurance Company
American Empire Surplus Lines Insurance Company
American Empire Insurance Company
GAI Warranty Company
GAI Warranty Company of Florida
Dempsey and Siders, Inc.
Eden Park Insurance Brokers, Inc.
Professional Risk Brokers, Inc.
ABA Insurance Services Inc.
Great American Insurance Agency, Inc.
Premier Lease & Loan Insurance Services Insurance Agency, Inc.

In Witness Clause

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**