



QBE INSURANCE CORPORATION

Administrative Office
New York, New York 10005

**APPLICATION FOR BLANKET ACCIDENT INSURANCE
Accidental Death and Accident Medical Benefits**

Part I Proposed Policyholder

AHH011593

a. Full Legal Name of Proposed Policyholder

b. Address City of Fort Collins, Colorado
PO Box 580
Fort Collins, CO 80522

c. Proposed Policyholder is: Organization

d. Requested Effective Date: 5/1/2017
Policy will become effective on the Requested Effective Date only if (a) all required information is provided and (b) all required premium is paid.

e. Who will be insured? Eligible Persons participating in Covered Activities as shown on the Schedule of Benefits.

Part II Plan of Insurance and Premium Calculation

Annual Premium: \$4,846.00

Plan of Benefits: Accident Medical Expense Benefits \$10,000

Scope of Coverage: Full Excess **Deductible:** \$0
Accidental Death Benefit: \$2,500 **Accidental Dismemberment Benefit:** Up to \$2,500

Part III Acknowledgements and Signatures

a. Fraud Warning It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

b. Applicant's Acknowledgement I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of QBEIC will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of QBEIC, and (d) only those persons eligible under the terms of an issued policy will be insured.

Dated at _____ **on the** _____ **day of** _____ , **20** _____

Michael P. Seal

Signed for the Proposed Policyholder

Signed by Licensed Agent

On File

Title _____

Agent License Number _____



QBE INSURANCE CORPORATION

Administrative Office

Wall Street Plaza, 88 Pine Street, 16th Floor
New York, NY 10005

POLICYHOLDER: City of Fort Collins, Colorado

GROUP POLICY NUMBER: AHH011593

POLICY EFFECTIVE DATE: 5/1/2017

POLICY ISSUE DATE: May 19, 2017

POLICY TERM 5/1/2017 to 5/1/2018

STATE OF ISSUE: Colorado

QBE Insurance Corporation, herein called the Company or We, Us or Our, in consideration of the Application for this Policy and the timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the Policyholder's eligible member.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if premium is paid according to agreed terms.

This Policy terminates at 12:01 AM on the last day of the Policy Term unless the Policyholder and We have agreed to continue this Policy for an additional Policy Term. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

IN WITNESS WHEREOF QBE Insurance Corporation has caused this Policy to be executed on its Issue Date, to take effect on the Effective Date.

Russell Johnston, President

Jose Ramon Gonzalez, Secretary

**• BLANKET ACCIDENT POLICY •
• NON-PARTICIPATING •**

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY BENEFITS FOR SICKNESS

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

Eligible Persons: All authorized volunteers of the Policyholder.

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverage.

Policyholder Coverage	
Personal Deviations covered	No
Covered Activity Travel Limits	
Travel arranged or provided by the Policyholder	No time limit

Covered Activities Participation in and attendance at the following Policyholder Supervised and Sponsored activities: All authorized volunteer activities. Overnight Supervised and Sponsored Activities with duration of over 7 days and related travel are not covered, unless specifically agreed to in writing by Us.

INDEMNITY BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss must occur within

365 days of the Covered Accident

Covered Loss	Schedule of Covered Losses Benefit
Loss of Life	\$2,500
Loss of Two or More Hands or Feet	\$2,500
Loss of Sight of Both Eyes	\$2,500
Loss of One Hand or Foot and Sight in One Eye	\$2,500
Loss of Speech and Hearing	\$2,500
Quadriplegia	\$2,500
Paraplegia	\$2,500
Hemiplegia	\$2,500
Loss of One Hand or Foot	\$1,250
Loss of Sight in One Eye	\$1,250
Loss of Speech	\$1,250
Loss of Hearing in Both Ears	\$1,250
Loss of Thumb and Index Finger of the Same Hand	\$625
Aggregate Limit of Indemnity	\$500,000
Applies to:	All Conditions of Coverage

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses suffered by all Covered Persons insured under this Accidental Death and Dismemberment Benefit as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. If this amount does not allow all Covered Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENT MEDICAL EXPENSE BENEFITS

Any benefit limits and Benefit Percentages for Accident Medical Expense Benefits apply, unless otherwise specified, on a per-Covered Person – per Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

Scope of Coverage Applicable to Accident Medical Benefits

Full Excess Medical Expense	
Other Health Plan Reduction	50%

Medical Expense Benefits

Total Maximum for all Accident Medical Expense Benefits	\$10,000
First Covered Expenses must be Incurred within Benefit Period	180 days after a Covered Accident 104 weeks from the date of the Covered Accident
Deductible applies to	\$0 each Covered Accident
does not	include Covered Expenses paid under another Health Care Plan

Covered Expense

Benefit Amount, Percentage, Other Limits

In-Patient Hospital Services

Daily ICU or CCU Benefit	100%, up to two times the average semi-private room rate
Daily In-Hospital Benefit	100% of the average semi-private room rate
Miscellaneous Services	100%

Ambulatory Medical Center

100%

Emergency Room Treatment

100%

Physician Services

Surgery Benefit	100%
Assistant Surgeon	100%
Physician's Surgical Facilities	100%
Second Opinion or Consultation	100%
Physician's Assistant	100%
Anesthesia Benefit	100%
Inpatient Visits	100%
Office Visits	100%

Outpatient X-Ray, CT Scan, MRI and Laboratory Tests	100%
Outpatient Physiotherapy	100%
Outpatient Nursing Services	100%
Ambulance Services	100%
Medical Equipment Rental	100%
Medical Services and Supplies	100%

Covered Services include:

- (a) initial artificial limbs, eyes and larynx, including fitting; and
- (b) replacement or repair of damaged eyeglasses, contact lenses or hearing aids.

Dental Services	100%
Prescription Drug Benefit	100%

RATE TABLE

Premium \$4,846.00
Minimum Premium: \$300.00

Mode of Premium Payment Annual

Premium Due Date Policy Effective Date

Contributions The cost of this insurance is paid by the Policyholder. Minimum and deposit premiums are fully earned and non-refundable.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Aircraft means a vehicle which has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the Aircraft.

Appropriate Treatment means care, services or supplies, provided by or at the direction of a Physician that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury and are provided during the course of treatment of an injury sustained in a Covered Accident. Appropriate Treatment must be provided no less frequently than monthly, unless the Covered Person's Physician specifies in writing to Us that such treatment of injuries sustained in a Covered Accident can be provided at less frequent intervals.

Benefit Percentage means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the *Schedule of Benefits*.

Covered Activity means any recurring activity that is shown in the *Schedule of Benefits* and:

1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits*; and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

Company or We, Us, Our, means QBE Insurance Corporation (QBEIC), domiciled in Pennsylvania.

Covered Accident means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in an injury or loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, sickness, or mental or bodily infirmity; and
3. is not otherwise excluded under the terms of this Policy.

Covered Expenses means the lesser of the Usual and Customary Charge and the maximum benefit shown, for services or supplies listed, in the *Schedule of Benefits* and described in the *Accident Medical Expense Benefits* section of this Policy. Covered Expenses must be Incurred by a Covered Person for Appropriate Treatment for injuries sustained in a Covered Accident.

Covered Person means an Eligible Person, as defined in the *Schedule of Benefits*, whom for required premium has been paid when due and for whom coverage under this Policy remains in force.

Deductible means the amount of Covered Expenses that each Covered Person must Incur before benefits are paid under this Policy. The Covered Person may use Covered Expenses paid under another Health Care Plan to satisfy the Deductible under this Policy only if so indicated in the *Schedule of Benefits*.

He, Him or His means an individual, male or female.

Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice and individual practice plans;
5. medical benefits provided under automobile "fault" and no-fault – type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
 - a. a state-sponsored Medicaid plan; or
 - b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, or educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person Incurs an expense.

Hospital Stay means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident.

Incurred or Incurs means an obligation to pay for a Covered Expense for treatment, service or purchase of supplies, deemed to be the date it is provided to the Covered Person.

In-Patient means a Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse means a licensed registered nurse (R. N.) or a licensed practical nurse (L. P. N.) who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household; or
4. a person employed or retained by the Policyholder.

Out-Patient means a Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Personal Deviation means any activity which:

1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the *Conditions of Coverage* section of the *Schedule of Benefits*.

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the Policyholder; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Usual and Customary Charge means the normal charge, in the absence of insurance, made by the provider of any Appropriate Treatment, but not more than the prevailing charge in the area:

1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date

We agree to provide Blanket Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

Eligibility

An individual becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals

Insurance becomes effective for an Eligible Person on the latest of the following dates:

1. the effective date of this Policy; and
2. the date the individual becomes eligible.

Effective Date of Changes

Any increase or decrease in the amount of insurance for a Covered Person resulting from a change in benefits provided by this Policy will take effect on the date of such change.

Termination of Insurance

The insurance on a Covered Person will end on the earliest date below:

1. the date the person is no longer in an Eligible Class;
2. the end of the last period for which premium is paid; or
3. the date this Policy terminates.

Termination will not affect a claim for a Covered Loss resulting from a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit or Maximum, as shown in the *Schedule of Benefits*, have been paid;
3. the date benefits paid equal any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits*.

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. travel or activity outside the United States or Canada;
12. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. injuries compensable under Workers' Compensation law or any similar law;

We will not pay benefits for:

15. services or treatment rendered by a Physician, Nurse or any other person who is:
 - a. employed or retained by the Policyholder;
 - b. living in the Covered Person's household;
 - c. who is a parent, sibling, spouse or child of the Covered Person;
16. any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.
17. A Covered Person's Covered Loss if:
 - a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and
 - b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Notice can be given to Us at Our Administrative Office in New York, New York, to such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Claim Forms

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Beneficiary

The beneficiary is the person or persons the Covered Person names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes or to make any assignment of rights or benefits permitted by this Policy, unless the beneficiary has been designated as an irrevocable beneficiary.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the Covered Person.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

Cancellation

We or the Policyholder may cancel this Policy as of any Premium Due Date by giving the other 60 days advance written notice. Any premium rate guarantee will not affect Our or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, We will cancel this Policy at the end of the last period for which premium was paid, subject to any Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*.

Cancellation will not affect a claim for a Covered Loss resulting from a Covered Accident that occurred before the cancellation date.

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Payment

The total premium paid by the Policyholder is the sum of premiums for all Covered Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits*, unless the Policyholder and We agree to another mode of premium payment. Premiums are paid at our Administrative Office or to Our authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates

We may change the premium rates from time to time with at least 31 days advance written notice to the Policyholder. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects Our benefit obligations under this Policy; or
3. the Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

We will have the right to audit books and records of the Policyholder at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to the earliest period for which premium was not previously paid.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Misstatement of Fact

If a Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Assignment

The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.

Incontestability

1. Of This Policy

All statements made by the Policyholder to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

Reporting Requirements

The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by Us.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

CONDITIONS OF COVERAGE

This section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

POLICYHOLDER COVERAGE

Provisions and exclusions for travel apply only if indicated on the Schedule of Benefits.

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when a Covered Person suffers a Covered Loss or Incurs Covered Expenses resulting, directly and independently of all other causes, from a Covered Accident that occurs during one of the Covered Activities shown in the *Schedule of Benefits*.

The Covered Activity must take place:

1. under one of the Conditions of Coverage shown in the *Schedule of Benefits*; and
2. on the premises of the Policyholder during normal hours of operation or during another scheduled time; or
3. at another site designated by the Policyholder where the Covered Activity is scheduled.

This Coverage also includes travel only within the United States and only directly and without interruption;

1. between the Covered Person's home or another meeting place designated by the Policyholder and the site of the Covered Activity; and
2. by common carrier or Policyholder arranged or provided transportation to the site of the Covered Activity, or by a private passenger automobile driven by an adult with a valid drivers' license.

Exclusions This coverage will not be in effect during:

1. the Covered Person's Personal Deviation; or
2. during travel to any Covered Activity that takes place outside the United States unless We have agreed to provide it in advance.

Other exclusions that apply to this coverage are in the *Common Exclusions* section.

ACCIDENT INDEMNITY BENEFITS

This Section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts and any applicable time requirements and limitations are shown in the *Schedule of Benefits*. Please read this and the *Common Exclusions* section in order to understand all of the terms, conditions and limitations applicable to these benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.

If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the largest Benefit payable for a Covered Loss.

Definitions *Each definition described below will apply to this Policy only if a corresponding Covered Loss is listed for it in the Schedule of Benefits.*

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

SCOPE OF COVERAGE APPLICABLE TO MEDICAL EXPENSE BENEFITS

Only the Scope of Coverage listed on the Schedule of Benefits will apply.

Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits*.

Other Health Care Plan Benefits

When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

Primary Medical Expense

We will pay Covered Expenses without regard to any Health Care Plan the Covered Person may have, after any applicable Deductible has been satisfied.

Primary Excess Medical Expense

We will pay Covered Expenses, up to the Primary Excess Benefit shown in the *Schedule of Benefits* after the Covered Person satisfies any applicable Deductible, without regard to any other Health Care Plan he may have. We then pay Covered Expenses only when they are in excess of amounts payable by any other Health Care Plan, whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits* if:

1. the Covered Person has coverage under another Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses will not be reduced for:

- (a) emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement; and
- (b) services rendered in a non-network facility or by a non-network provider, when such services are required for emergency treatment within 24 hours of a Covered Accident.

Full Excess Medical Expense

We will pay Covered Expenses:

1. after the Covered Person has satisfied any applicable Deductible; and
2. only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits* if:

1. the Covered Person has coverage under another Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses will not be reduced for:

- (a) emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement; and
- (b) services rendered in a non-network facility or by a non-network provider, when such services are required for emergency treatment within 24 hours of a Covered Accident.

Definitions For purposes of the Accident Medical Benefits provided by this Policy:

HMO or Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider or service.

PPO or Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform those services at rates lower than non-Preferred Providers.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits shown in the *Schedule of Benefits* for Covered Expenses Incurred by a Covered Person, subject to all applicable conditions and exclusions, for treatment of an injury that resulted directly and independently of all other causes from a Covered Accident.

Benefits will be paid:

1. when Covered Expenses Incurred exceed any applicable Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits*; and
2. as long as the first expense has been Incurred within the number of days specified in the *Schedule of Benefits*; and
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired; and
4. until the total of Covered Expenses paid equals any applicable Benefit Limit or maximum benefit shown in the *Schedule of Benefits*; and
5. until benefits paid equal the Maximum for Accident Medical Expense Benefits shown in the *Schedule of Benefits*.

Covered Expenses

Inpatient Hospital Services

Room and Board Expenses – We will pay for

1. confinement in an intensive or coronary care unit, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of such confinement; and
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses – We will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for outpatient surgery. Miscellaneous Expenses include, but are not limited to, X-ray, laboratory, in-Hospital physiotherapy, nurse services, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay.

Ambulatory Medical Center

We will pay Covered Expenses Incurred for medical or surgical treatment provided in a licensed facility that provides ambulatory surgical or medical treatment and is not a Hospital or Physician's office.

Emergency Room Treatment

We will pay Covered Expenses Incurred for outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits*. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense.

Physician Services – We will pay Covered Expenses for Covered Expenses listed below.
Surgery

1. Covered Expenses charged for performing a surgical procedure through one incision. For the second procedure through the same incision, during the same surgical session, we will pay up to an additional 50% of the benefit payable for the primary surgical procedure. For the third procedure and each procedure thereafter through the same incision, during the same surgical session, we will pay up to an additional 25% of the benefit payable for the primary surgical procedure; and
2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure;

3. Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital or an ambulatory surgical center;
4. Any braces, splints or other devices required after surgery to ensure proper healing.

Use of Physician's Surgical Facilities – Covered Expenses charged for the use of a Physician's surgical facilities.

Second Opinion or Consultation – Covered Expenses charged by a Physician for a second surgical opinion or consultation.

Physician's Assistant – Covered Expenses charged by a Physician's Assistant for other than pre-or post-operative care, second opinion or consultation:

1. for in-Hospital visits; and
2. for office visits.

Anesthesia and its administration – Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre-or post-operative care, second opinion or consultation;

1. for in-Hospital visits; and
2. for office visits.

Outpatient X-Ray, CT Scan, MRI and Laboratory Tests

We will pay Covered Expenses Incurred for X-rays except dental X-rays, CT Scans, MRI's and laboratory tests.

Outpatient Physiotherapy

We will pay Covered Expenses Incurred for outpatient physiotherapy, which includes (a) acupuncture, (b) microthermy, (c) chiropractic adjustment, (d) manipulation, (e) diathermy, (f) massage therapy, (g) heat treatment, and (h) ultrasound treatment.

Outpatient Nursing Services

We will pay Covered Expenses Incurred for services other than routine Hospital care, rendered by a Nurse.

Ambulance Services

We will pay Covered Expenses Incurred for ground or air ambulance service to transport a Covered Person from the place where a Covered Accident occurred to the nearest medically appropriate facility. We will pay Covered Expenses Incurred for ground ambulance transportation from the nearest medical facility to another appropriate medical facility if a Physician specifies in writing that specialized care not available in the first facility to which the Covered Person was transported is necessary to treat his injury.

Medical Equipment Rental

We will pay Covered Expenses Incurred for rental or, if less, for purchase of:

1. a wheelchair or hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Covered Person and that can only be used by him. Examples of items that are not covered include but are not limited to computers, motor vehicles and modifications thereof, and ramps and installation costs.

Medical Services and Supplies

We will pay Covered Expenses Incurred for:

1. blood and blood transfusions, including processing and administration; and
2. cost and administration of oxygen and other gasses.

We will not pay for storage of blood for any reason.

Dental Services

We will pay Covered Expense Incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include examinations, X-rays, restorative treatment, endodontics, oral surgery, initial braces required for treatment of an injury and treatment of gingivitis resulting from trauma.

Covered Expenses must be Incurred within the Benefit Period shown in the *Schedule of Benefits*. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

We will pay Covered Expenses Incurred for drugs that

1. can only be obtained through a Physician's written prescription; and
2. are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay Covered Expenses Incurred for drugs that meet (a) above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA. The Covered Expense for a prescription drug is limited to the cost of a generic drug unless substitution of a generic drug is prohibited by law, no generic drug is available, or the Covered Person's Physician specifically request that a non-generic drug be dispensed.

Excluded Expenses

None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - a cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
 - b reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations.
4. Examination or prescriptions for, or purchase of, eyeglasses, contact lenses or hearing aids.
5. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.

8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. Personal services such as television and telephone, or transportation.
10. Expenses payable by any automobile insurance policy without regard to fault.
11. Services or treatment provided by an infirmary operated by the Policyholder.
12. Treatment of injuries that result over a period of time, such as blisters, tennis elbow, et al, that are a normal, foreseeable result of participation in the Covered Activity.
13. Treatment or service provided by a private duty nurse.
14. Treatment of hernia of any kind.
15. Treatment of injury resulting from a condition that a Covered Person knew existed on the date of a Covered Accident, unless we have received a written medical release from his Physician.

Other Exclusions that apply to this Benefit are in the *Common Exclusions* Section.



**SUMMARY OF THE LIFE AND HEALTH INSURANCE
PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING
COVERAGE LIMITATIONS AND EXCLUSIONS**

INTRODUCTION

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. 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. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection 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 Colorado. You should not rely on coverage by the Life and Health Insurance Protection 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.

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 Association to induce you to purchase any kind of insurance policy.

box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

SUMMARY

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. 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 Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

(Continued on Reverse Side)

This Information is Provided By:

Life and Health Insurance Protection Association
P.O. Box 36009
Denver, Colorado 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

EXCLUSIONS FROM COVERAGE. Persons holding such policies or contracts are **not** protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens or permanent residents of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

LIMITS ON AMOUNT OF COVERAGE. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - \$100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; \$300,000 for disability insurance; or \$500,000 for basic hospital, medical and surgical, or major medical insurance;
- \$100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, \$100,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.

The Association shall not be liable to expend more than \$300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed \$500,000 with respect to any one individual.

NOTICE OF QBE[®] PRIVACY POLICIES AND PRACTICES

FACTS	WHAT DOES QBE DO WITH YOUR PERSONAL INFORMATION?
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Why?	Your privacy is important to us. At QBE, we know that you have an interest in how we collect, keep, and use customer information.
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What?	<p>At QBE, we collect, keep and use information about our customers to serve their insurance needs. QBE and our agents may collect the following information about you and people covered under your policy:</p> <ul style="list-style-type: none"> • Information included on your applications or other forms. (For example, name, address, and Social Security number). • Information about your transactions with us or our affiliates. (For example, services purchased and payment history). • Information from consumer reporting agencies and insurance-support organizations. (For example, credit relationships and history, motor vehicle reports and claims history). • Information from other sources. (For example, medical information and demographic information). • Information from visits to the QBE web site.
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How?	All financial companies need to share customers' information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' information; the reasons QBE chooses to share; and whether you can limit this sharing.
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Reasons we can share your personal information	Does QBE share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For joint marketing with other financial companies.	No	We don't share
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 don't share
For affiliates to market to you – to offer our products and services to you.	Yes	No
For nonaffiliates to market to you	No	We don't share

Questions?	Please Contact: QBE Americas, Inc. Attn: Privacy Official Corporate Legal Department One General Drive Sun Prairie, WI 53596 1.800.362.5448
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Who we are	
Who is providing this notice?	QBE U.S. legal entities that use the names listed on page 3 of this Notice.

What we do	
How does QBE 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.
How does QBE collect my personal information?	If we need to confirm or obtain additional information about our customers, we may contact outside sources. These sources may include agents, brokers, insurance support organizations, consumer reporting agencies, medical providers and government agencies. The information we collect from these outside sources may include claims history, employment information and medical reports. Information obtained from outside sources may be kept by these outside sources and disclosed to other persons, as permitted by law.
Why can't I limit all sharing?	Federal law gives you the right to limit some but not all sharing related to: <ul style="list-style-type: none"> • affiliates' everyday business purposes — information about your credit worthiness • affiliates from using your information to market to you • nonaffiliates to market to you <p>State laws and individual QBE companies may give you more rights to limit sharing.</p>

Definitions	
Affiliates	Companies related by common ownership or control. They can be insurance and non-insurance companies. Our affiliates include companies listed on page 3 of this Notice.
Nonaffiliates	Companies not related by common ownership or control. They can be insurance and non-insurance companies.
Third Parties	<p>QBE carefully chooses service providers to help us provide quality insurance services to our customers. We are careful to protect customer privacy when we share information with them. We may share customer information with the types of third parties listed below.</p> <ul style="list-style-type: none"> • Financial service providers. (For example, insurance agents). • Hospitals, medical clinics or physicians. • Adjusters, appraisers, investigators and attorneys (To investigate or settle a claim involving you). • Insurance-support organizations that help detect and prevent insurance crimes or fraudulent claims (such as the National Insurance Crime Bureau). Information collected by such organizations may be kept by them and later shared with others who use these reports. • People that conduct actuarial or underwriting studies. • Companies that perform services for us or on our behalf. (For example, vendors we hire to respond to customer requests or to maintain or develop software for us). <p>We require third parties to comply with strict standards regarding security and confidentiality of customer information. They are not permitted to release customer information or use it for their own purposes. Third parties are also not allowed to sell any customer information we share with them to any other party.</p> <p>There may be times when we are required by law to disclose information about you to nonaffiliated third parties. For example, we may disclose information in response to a subpoena. We may share information to help detect or prevent fraud. We may have to give information to law enforcement or governmental agencies. We also may share information if you give us written permission first.</p> <p>We do not sell or share customer information to or with any party outside of QBE for purposes of independently selling their products to our customers.</p>

Other important information

How You Can Review Recorded Information About You:

People covered under your policy have the right to review information about them in our files. They may write us at the address shown on this notice if they want to know what information we have on file. We will need their complete name, address, date of birth, and all your policy numbers. They will need to tell us what information they would like to receive or view. We will act on their request within 30 days of receiving it. We will let them know the nature of the information about them in our files. We will tell them with whom we have shared this information in the past two years. We will also give them the name and address of any consumer reporting agency that prepared a report about them in our files. They can contact the consumer reporting agency to get a copy of that report.

If they would prefer to view and copy the information in the file in person, they will need to let us know in their request.

If You Disagree With Our Records:

A person covered under your policy should contact us if they think any of our information is incorrect. They should tell us what is wrong and why. They may ask us to correct, amend or delete it. Within 30 days of receiving their request, we will change their information in our files or let them know that we refused to change their information.

If we make any changes to their information, we will let them know of those changes. We will also let the parties listed below know of those changes.

- Any party that may have, in the past 2 years, been given such information.
- Any insurance-support organization that we have given the information to within the past 7 years.
- Any insurance-support organization that gave us the information.
- Consumer Reporting Agencies (CRAs).

If we do not make changes, we will give them the reasons why and let them know of their right to file a statement. Their statement should tell us what they think is the correct information. They should also tell us why they disagree with our refusal. Their statements will be kept in their file and given to anyone that reviews the information. If we need to disclose the disputed information, we will mark the matter(s) in dispute and include their statement(s).

Privacy Policy Changes: We will notify you if we make changes to our privacy policy. We may make changes to comply with applicable laws or to conform to our current business practices. QBE reserves the right to change its privacy policies at any time.

QBE U.S. legal entities

This notice is being provided on behalf of the following QBE affiliates:

QBE Insurance Corporation	Southern Pilot Insurance Company
QBE Specialty Insurance Company	Southern Fire & Casualty Company
General Casualty Company of Wisconsin	Unigard Insurance Company
General Casualty Insurance Company	Unigard Indemnity Company
Blue Ridge Indemnity Company	Praetorian Insurance Company
Regent Insurance Company	North Pointe Insurance Company
Hoosier Insurance Company	Stonington Insurance Company
Southern Guaranty Insurance Company	QBE Americas, Inc.

QBE is a registered service mark of QBE Insurance Group Limited.