Group Accident Policy

ZURICH

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

In return for the payment of premium expressed in the **Schedule**, **We** agree to pay the benefits of this Group **Accident Policy** to the persons insured hereunder, subject to the terms and conditions, which follow. **We** have issued the Group **Accident Policy** to the **Policyholder**. The Group **Accident Policy** is executed as of the **Policy** date which is its date of issue, and from which anniversary dates are measured. The Group **Accident Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

THIS GROUP ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE ONLY
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

POLICYHOLDER: North Lamar Independent School District
3201 Lewis Lane
Paris, TX 75462

POLICY NUMBER: GTU 5091254

POLICY DATE: September 1, 2009 to Continuous
Hereafter the Anniversary date for this **Policy** will be October 1.
(All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

CONTRACT SITUS: Texas

The following pages, including any riders, endorsements, schedule pages, **Insured** enrollment forms, applications or amendments, are a part of this Group **Accident Policy**. **We** and the **Policyholder** have agreed to all the terms of this Group **Accident Policy**.

This is a legal contract between the **Policyholder** and **Us**.
READ THE GROUP **ACCIDENT POLICY** CAREFULLY

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

Nancy D. Mueller
President
Zuric
h American Insurance Company

Dennis F. Kerrigan, Jr.
Corporate Secretary

Zurich American Insurance Company

NON-PARTICIPATING

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SECTION I – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

ELIGIBILITY AND CLASSIFICATION OF INSUREDS:

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

Class I: All **Active** full-time Employees domiciled in the United States.

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF INSURED'S DEPENDENTS:

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

EFFECTIVE DATE OF INSURANCE FOR THE INSURED:

A. For eligible individuals hired prior to September 1, 2009:
September 1, 2009, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For eligible individuals hired on or after September 1, 2009:
on the first day of the month following the date the completed enrollment material is received by the **Policyholder**.

SECTION II – SCHEDULE

COVERAGE(S):	**Classes Covered**
24 Hour **Accident** Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft, H-1	All
Exposure and Disappearance Coverage	All

BENEFITS:	**Classes Covered**
Accidental Death Benefit	All

Principal Sum:

Class I: An employee may purchase an amount of **Principal Sum** from a minimum of $10,000 to a maximum of $500,000 in increments of $10,000. However, amounts applied for in excess of $250,000 must not exceed ten (10) times the employee's **Base Annual Earnings***.

* **Base Annual Earnings** means the employee's base annual pay excluding overtime, bonuses, commissions and special compensation.

The **Principal Sum** for **Covered Dependents** will be a percentage of the **Insured's Principal Sum**, as follows:

Spouse: An employee may purchase an amount of **Principal Sum** for his or her **Spouse** from a minimum of $5,000 to a maximum of $250,000 in increments of $5,000. In no event will the **Spouse's** amount be more than 50% of the **Insured's Principal Sum**.

Dependent Child(ren): An employee may purchase an amount of **Principal Sum** for his or her **Dependent Child(ren)** from a minimum of $5,000 to a maximum of $50,000 in increments of $5,000. In no event will the **Dependent Child(ren)'s** amount be more than 10% of the **Insured's Principal Sum**.

At age 70, for the **Insured** employee only, the **Principal Sum** will be reduced based on the **Insured** employee's previous **Principal Sum** per the following schedule:

Age at Date of Loss	**Percent of Principal Sum**
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

Escalator Clause

We will increase the **Accidental Death Benefit** for the **Insured** at an amount equal to 2% of the **Insured's Principal Sum** for each year the **Insured** remains continuously covered under this **Policy** for a maximum of five (5) years. If the **Insured** selected a **Plan** covering his or her **Dependent(s),** the **Principal Sum** for his or her **Covered Dependent(s)** will be calculated from the **Insured's** original **Principal Sum**, and therefore this increase does not affect the **Covered Dependent's Accidental Death Benefit(s)**.

The first increase will take effect one year from the **Policy** anniversary date that is equal to or later than the date the **Insured** became eligible for benefits under this **Policy**. Future increases will take effect on subsequent **Policy** anniversary dates. The increase will be based on the **Insured's Principal Sum** on the day immediately prior to the **Policy** anniversary date.

BENEFITS continued:	**Classes Covered**
Accidental Dismemberment and Plegia Benefit	All

Principal Sum:

Same as above.

ADDITIONAL BENEFITS:	**Classes Covered**
Additional Dismemberment Benefit for Children	All
Critical Burn Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Rehabilitation Benefit	All
Seat Belt/Air Bag Benefit	All
Travel Assistance Plan	All

Enrollment Required:		Yes
Premium Due Date:		First day of each month
Premium:	Employee Only:	$0.026 per $1,000 of **Principal Sum** per month
	Spouse Only:	$0.026 per $1,000 of **Principal Sum** per month
	Dependent Child(ren) Only:	$0.026 per $1,000 of **Principal Sum** per month
		These rates are guaranteed until September 1, 2010.

SECTION III – DEFINITIONS

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

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

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

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

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

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

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

Covered Injury means an **Injury** directly caused by accidental means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under this **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under this **Policy**.

Covered Person means any person who has insurance under the terms of this **Policy**. It includes the **Insured** and his or her **Spouse** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** and/or **Dependent Child(ren)** is selected.

Dependent means an **Insured's Spouse** and **Dependent Child(ren),** as defined in this section. The **Dependent** will only be a **Covered Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren), if used in this **Policy,** means those unmarried **Child(ren)** of the **Insured** who rely on the **Insured** for more than 50% of their support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 25 (twenty-five) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Injury means a bodily **Injury**.

Insured means an individual who is eligible for **Coverage** under this **Policy** as provided in the Eligibility and Classification of Insureds part of Section I, and who completes the enrollment material, if required.

Owned Aircraft means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.

Plan means the **Plan** design as described on the Schedule**.**

Policy means this Group **Accident** Insurance **Policy**.

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

Specialized Aviation Activity means an aircraft while it is being used for one or more of the following activities:

- acrobatic or stunt flying
- aerial photography
- banner towing
- bird or fowl herding
- crop dusting
- crop seeding
- crop spraying
- endurance tests
- exploration
- fire fighting
- flight on a rocket-propelled or rocket launched aircraft
- flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted
- hang gliding
- hunting
- parachuting or skydiving
- pipe line inspection
- power line inspection
- racing
- skywriting
- test or experimental purpose

Spouse, if used in this **Policy,** means the **Insured's** legally married **Spouse** under age 70. A **Spouse** will only be a **Covered Spouse** if a **Plan** covering the **Insured's Spouse** is selected.

Under lease, as used in the **Coverages** Section**,** means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

We, Us, and **Our** refers to Zurich American Insurance Company.

SECTION IV – COVERAGES

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

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

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

Hazard Limitations:

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

A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

1. medical certificate; and

2. pilot certificate with a proper rating to pilot such aircraft.

B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft.

B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

1. any aircraft other than those expressly stated in this **Coverage**;

2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**.

3. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of a **Covered Person's** family or household;

4. any aircraft operated by the **Policyholder** or one of the Policyholder's employees including members of an employee's family or household;

5. any aircraft engaged in a **Specialized Aviation Activity;**

6. any conveyance used for tests or experimental purposes, or in a race or speed test.

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

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

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

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

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

ACCIDENTAL DISMEMBERMENT AND PELGIA BENEFIT

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

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

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

Plegia

1. Quadriplegia (total paralysis of all four **Limbs**)	**Principal Sum**
2. Paraplegia (total paralysis of both lower **Limbs**)	75% of **Principal Sum**
3. Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	50% of **Principal Sum**

For purposes of this benefit:

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

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

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

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

CRITICAL BURN BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** as a result of a **Covered Accident,** which is payable under the **Accidental Dismemberment and Plegia Benefit,** an additional benefit will be based on the **Principal Sum** of the person suffering the **Critical Burn** as follows.

Body Part:	**Maximum Benefit Amount Payable:**
1. Face, Neck, Hand	50% of **Principal Sum**
2. One Hand & Forearm	20% of **Principal Sum**
3. One Upper Arm	10% of **Principal Sum**
4. Front or Back Torso	25% of **Principal Sum**
5. One Thigh or One Lower Leg (below knee)	5% of **Principal Sum**

To be eligible for this benefit, the following terms and conditions of the **Policy** are met and:

1. the **Covered Person** has received third degree burns over his or her body; and
2. the **Covered Person** has undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within 365 days of the occurrence of the **Injury**.

HIGHER EDUCATION BENEFIT

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

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

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

The **Higher Education Benefit** will be equal to 5% of the **Insured's Principal Sum**, to a maximum of $5,000. This amount will be paid annually for four (4) consecutive years if the **Covered Dependent Child** continues his or her education. Before this benefit is paid each year, the **Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering the **Insured's Dependents** was selected, but there are no **Covered Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of $2,000 to the designated beneficiary.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

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

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

Benefits will not be payable unless:

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

The maximum amount payable under all provisions of this benefit combined will be the lesser of $5,000 for the one time cost for one alteration or $10,000 for both.

REHABILITATION BENEFIT

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

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

Rehabilitation Training means a treatment program that:

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

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

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

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

SEAT BELT/AIR BAG BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of $10,000, provided that the **Covered Person** was:

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

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

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

An additional benefit of $5,000, will be paid if the **Covered Person** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt** or **Air Bag Benefit** if the driver of the automobile in which the **Covered Person** was riding was either:

1. under the influence of alcohol;
   a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

TRAVEL ASSISTANCE PLAN

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

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation

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

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

Continued

Medical Repatriation

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

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

Return of Remains

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

Visit to Hospital

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

Return of Child

If a **Covered Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person,** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person,** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion

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

Continued

- **TRAVEL ASSISTANCE EXCLUSIONS**

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

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

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

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

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

"Principal Residence" means the legal domicile of the **Covered Person.**

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

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

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

Reservation of Rights

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

Continued

Scope

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

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

SECTION VII – GENERAL EXCLUSIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted, medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony or an assault;
6. parasailing, bungee jumping, or any other extra-hazardous activity;
7. being intoxicated.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
8. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
9. travel or flight in any aircraft except to the extent stated in the **Coverage** Section;
10. release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
11. a cardiovascular event or stroke caused by exertion prior to or at the same time as an Accident;
12. alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider operating within his or her scope of authority.

SECTION VIII – GENERAL LIMITATIONS

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

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

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

SECTION IX - TERMINATION OF INSURANCE

A. Policy Termination.

Termination by **Policyholder**. The **Policyholder** may terminate this **Policy** on the first renewal date or at any time after that date by delivering to **Us** a written notice to end this **Policy** at least thirty (30) days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

Termination by Us. **We** may terminate this **Policy** by giving the **Policyholder** at least thirty (30) days notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** may also end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the **Grace Period**. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

B. Termination of Individual's Insurance.

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

1. the **Policy** is terminated;
2. the **Insured** ceases to be eligible for insurance;
3. the **Insured** fails to pay the required premium, if the **Insured** is so required;
4. the **Insured** retires.

Covered Person other than the **Insured.** Insurance terminates on the earliest of:

1. the date the insurance of the **Insured** terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**;
3. for the **Covered Spouse**, the date the **Covered Spouse** reaches age 70.

Conversion Privilege

If the insurance of an **Insured** ceases for reasons other than termination of the **Policy** or nonpayment of premium, the **Insured** is entitled to convert his or her **Coverage** to an **Individual Accidental Death or Dismemberment** (**IAD)** policy or to a **Family AD&D** (**FAD)** policy if the **Insured** selected a **Plan** covering his or her **Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. The **Insured** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of insurance under the Group **Accident Policy**. To request a Conversion Application Form, the **Insured** must call 1-877-276-6158. The **Insured** does not have to show proof of good health.

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

1. the **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of the **Insured's Principal Sum** under the Group **Accident Policy** or $750,000;
2. the premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any **IAD** or **FAD** policy issued will take effect on the termination date of the **Insured's** insurance under the Group **Accident Policy**; and
4. when an **IAD** or **FAD** policy becomes effective, the relationship between the **Insured** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

The **Conversion Privilege** will cease when the **Insured** attains age 70.

SECTION X - HOW TO FILE A CLAIM

A. Notice. The **Insured** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, the **Insured**, and the **Policy** Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

B. Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

C. Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss,** and the proof was provided as soon as reasonably possible.

SECTION XI - PAYMENT OF CLAIMS

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

B. Who We Will Pay.

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

- **a.** the **Insured's** legally married **Spouse**;
- **b.** the **Insured's Child(ren)**;
- **c.** the **Insured's** parents;
- **d.** the **Insured's** brothers and sisters;
- **e.** the **Insured's** estate.

2. Loss of Life of a **Covered Person** other than the **Insured**. **Covered Losses** for the death of a **Covered Person** other than the **Insured** will be paid to the **Insured**. If the **Insured** pre-deceases or dies at the same time as the **Covered Person** other than the **Insured**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to the **Insured's** estate.

3. All Other Claims. Benefits are to be paid to the **Covered Person**. He or she may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the **Covered Person** at any time up to the filing of the proof of **Covered Loss**.

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

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

SECTION XII - GENERAL POLICY CONDITIONS

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

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

C. Clerical Error. A clerical error or omission will not increase or continue an **Insured's Coverage**, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

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

E. Entire Contract. This **Policy**, the **Policyholder** application, **Insured** enrollment materials, and any attachments represent the entire insurance contract between the **Policyholder** and **Us**.

F. Grace Period. Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If the **Policyholder** does not pay a renewal premium when it is due, there is a thirty-one (31) day **Grace Period** to pay. During the **Grace Period**, the **Policy** will stay in force. The **Policyholder** will not have a **Grace Period** if **We** have given notice, at least thirty (30) days in advance, that **We** are going to terminate this **Policy**.

G. Insured Certificates. We will give to the **Policyholder** a **Certificate,** in either paper or electronic format, for their **Insureds,** where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**. Such **Certificate** will contain a summary of terms that affect benefits.

H. Policyholder Records. The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.

I. Suit Against Us. No action on this **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law.

J. Renewal. This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.

K. ERISA Claims Fiduciary. The **Policyholder** agrees that the **Policy** constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The **Policyholder** designates **Us** as the claims fiduciary of this plan and gives **Us** the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The **Policyholder** agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and **Our** designation and authority as the claims fiduciary.

L. Assignment of Interest. A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

M. Newly Acquired Corporation If the **Policyholder** acquires a corporation through stock purchase, exchange of stock or otherwise, and notifies **Us** of such acquisition within ninety (90) days thereafter, the eligible employees of the **Newly Acquired Corporation** will be insured under this **Policy** as of the effective date of such acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, within the ninety (90) days, or does not pay such additional premium, if any, as required, the **Coverage** for the employees of the **Newly Acquired Corporation** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

Note: The above reporting provision only applies to corporations with more than 200 employees. For corporations with less than 200 employees, reporting of such acquisition will not be required, and **Coverage** will be automatic for the duration of the **Policy** term.

North Lamar Independent School District
GTU 5091254
Effective: September 1, 2009

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law if found in the *Texas Insurance Code*, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **residents of Texas** at the time that their insurance company is impaired;
- **residents of other states,** ONLY if the following conditions are met:
    1) the policyholder has a policy with a company based in Texas;
    2) the company has never held a license in the policyholder's state of residence;
    3) the policyholder's state of residence has a similar guaranty association; and
    4) the policyholder in *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:

- net cash surrender value up to $100,000 under one or more policies on any one life; or
- death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:

- net cash surrender amount up to a total of $100,000 under one or more policies owned by one contract holder.

Group Annuities:

- net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contract holder; or
- net cash surrender amount up to $5,000,000 in allocated benefits under one contract holder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSES OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, TX 78701
(800) 982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(800) 252-3439

Important Notice

Important Notice to Texas Customers:

To obtain information or make a complaint:

You may call Zurich North America's toll-free telephone number for information or to make a complaint at:

1-800-382-2150 (Monday through Friday, 9a.m. – 4 p.m.)

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax number (512) 475-1771

Premium or claim disputes:

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

Attach this Notice to your Policy:
This notice is for information only and does not become a part or condition of the attached document.

Texas Combined Policyholder Notice

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Zurich American Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-382-2150

You may also write to Zurich American Insurance Company at:

Customer Inquiry Center
1400 American Lane
Schaumburg, IL 60196-1056

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

1-800-252-3439

You may write to the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax #: (512) 475-1771

PREMIUM OR CLAIM DISPUTES

Should you have a dispute concerning your premium or about a claim, you should contact the Zurich American Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Zurich American Insurance Company para informacion o para someter una queja al:

1-800-382-2150

Usted tambien puede escribir a Zurich American Insurance Company:

Customer Inquiry Center
1400 American Lane
Schaumburg, IL 60196-1056

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, cobeturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax #: (512) 475-1771

DISPUTAS SOBRE PRIMAS OR RECLAMOS:

Si tiene una disputa concemiente a su prima o a un reclamo, debe comunicarse con Zurich American Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departmento (TDI).

UNA ESTE AVISO A SU POLIZA

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