United States Fire Insurance Company
Administrative Office: 5 Christopher Way,
Eatontown, NJ 07724
(Hereinafter referred to as "the Company")

TRAVEL PROTECTION INSURANCE POLICY

United State Fire Insurance Company, herein referred to as the Company, agrees to pay the benefits provided by this Policy in accordance with its provisions. This Policy provides group travel protection insurance coverage.

PLEASE READ THIS POLICY CAREFULLY FOR FULL DETAILS

This Policy is a legal contract and is issued in consideration of the Application of the Policyholder, a copy of which is attached.

INCORPORATION PROVISION: The provisions of this Policy and all amendments to this Policy after its effective date are made part of this Policy. This Policy was signed by the Policyholder on the application.

Signed for United States Fire Insurance Company By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

NON-PARTICIPATING POLICY
SHORT TERM COVERAGE
NON-RENEWABLE

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SECTION I. COVERAGES

TRIP CANCELLATION

Benefits will be paid, up to the Maximum Benefit Amount shown in the Insured's Schedule of Benefits, to reimburse the Insured for the amount of the Published Penalties and unused non-refundable Prepaid Payments or Deposits the Insured paid for Travel Arrangements when the Insured is prevented from taking the Insured's Trip due to:

1. The Insured's or a Family Member's or a Traveling Companion's death, which occurs before departure on the Insured's Trip;
2. The Insured's or a Family Member's or a Traveling Companion's covered Sickness or Injury, which: a) occurs before departure on the Insured's Trip, b) requires Medical Treatment at the time of cancellation resulting in medically imposed restrictions, as certified by a Legally Qualified Physician, and c) and prevents the Insured's participation in the Trip;
3. For the **Other Covered Reasons** listed below;

provided such circumstances occur while coverage is in effect.

"Other Covered Reasons" means:

a. The Insured or Insured's Traveling Companion being hijacked, quarantined, required to serve on a jury (notice of jury duty must be received after the Insured's Effective Date), served with a court order to appear as a witness in a legal action in which the Insured or the Insured's Traveling Companion is not a party (except law enforcement officers);

b. The Insured or Insured's Traveling Companion's primary place of residence or destination being rendered uninhabitable and remaining uninhabitable during the Insured's scheduled Trip, by fire, flood, burglary or other Natural Disaster. The Company will only pay benefits for Losses occurring within 30 calendar days after the Natural Disaster makes the Insured's destination accommodations

uninhabitable. The Insured's destination is uninhabitable if: (i) the building structure itself is unstable and there is a risk of collapse in whole or in part; (ii) there is exterior or structural damage allowing elemental intrusion, such as rain, wind, hail, or flood; (iii) immediate safety hazards have yet to be cleared such as debris on roofs or downed electrical lines; or (iv) the rental property is without electricity or water. Benefits are not payable if a storm, snow storm, blizzard or hurricane is named on or before the Effective Date of the Insured's Trip Cancellation coverage;

c. a documented theft of passports or visas;

d. The Insured or the Insured's Traveling Companion being directly involved in a traffic accident, substantiated by a police report, while en route to the Insured's scheduled point of departure;

e. The Insured or Insured's Traveling Companion is in the military and called to emergency duty for a national disaster other than war;

f. involuntary employer termination or layoff which occurs 30 days or more after the Insured's Effective Date of affecting the Insured or the Insured's Traveling Companion. Employment must have been with the same employer for at least 1 continuous year. The Insured will receive benefits up to 100% of the non-refundable Prepaid travel expenses**;**

g. revocation of the Insured's previously granted military leave or re-assignment due to war. Official written revocation/re-assignment by a supervisor or commanding officer of the appropriate branch of service will be required.

All cancellations must be reported to the Travel Supplier within 72 hours of the event causing the need to cancel. If the event delays the reporting of the cancellation beyond the 72 hours, the event should be reported as soon as possible. Increased amounts of Published Penalties and unused non-refundable Prepaid Payments or Deposits that result from all other delays of reporting beyond 72 hours are not covered.

Single Supplement

Benefits will be paid, up to the Maximum Benefit Amount, for the additional cost incurred as a result of a change in the per person occupancy rate for Prepaid Travel Arrangements if a Traveling Companion's or Family Member's Trip is canceled for a covered reason and the Insured does not cancel the Insured's Trip.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate Plan.

TRIP INTERRUPTION

Benefits will be paid, up to 100% of the total amount of coverage the Insured purchased, to reimburse the Insured for the Prepaid Payments or Deposits for unused non-refundable land or water Travel Arrangements plus the Additional Transportation Cost paid:

a) to join the Insured's Trip if the Insured must depart after the Insured's Scheduled Departure Date or travel via alternate travel arrangements by the most direct route possible to reach the Insured's Trip destination; or

b) to rejoin the Insured's Trip or transport the Insured to the Insured's originally scheduled return destination, if the Insured must interrupt the Insured's Trip after departure, each by the most direct route possible.

Trip Interruption must be due to:

1. The Insured's, a Traveling Companion's or a Family Member's death, which occurs while the Insured is/are on the Insured's Trip;
2. The Insured's, a Traveling Companion's or a Family Member's, covered Sickness or Injury which: a) occurs while the Insured is on the Insured's Trip, b) requires Medical Treatment at the time of interruption resulting in medically imposed restrictions, as certified by a Legally Qualified Physician, and c) prevents the Insured's continued participation on the Insured's Trip;

Additional Trip Interruption Benefits:

If the Insured cannot continue travel due to a covered Injury or Sickness not requiring hospitalization and the Insured must extend the Insured's Trip due to medically imposed restrictions, as certified by a Legally Qualified Physician, benefits will be paid for additional hotel nights, meal(s), telephone call and local transportation expenses up to $100 per day, limited to 5 days a maximum of $500.

Single Supplement

Benefits will be paid, up to the Maximum Benefit Amount, for the additional cost incurred as a result of a change in the per person occupancy rate for Prepaid Travel Arrangements if a Traveling Companion's or Family Member's Trip is interrupted for a Covered Reason and the Insured does not interrupt their Trip.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate.

TRAVEL DELAY

Benefits will be paid up to $500 per day for: 1) the non-refundable, unused portion of the Prepaid expenses for the Insured's Trip as long as the expenses are supported by proof of purchase and are not reimbursable by any other source; and 2) reasonable accommodation, meal, telephone call and local transportation expenses incurred by the Insured, up to the Maximum Benefit Amount shown in the Insured's Schedule of Benefits, if the Insured is delayed for 8 hours or more while en route to or from, or during the Insured's Trip, due to:

a) any delay of a Common Carrier (the delay must be certified by the Common Carrier);

b) a traffic accident in which the Insured or Insured's Traveling Companion are not directly involved (must be substantiated by a police report);

c) quarantine, hijacking, Strike, Natural Disaster, terrorism or riot;

d) a documented weather condition preventing the Insured from getting to the point of departure.

Benefits will not be paid for any expenses, which have been reimbursed, or for any services that have been provided by the Common Carrier.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate**.**

BAGGAGE AND PERSONAL EFFECTS

Benefits will be provided to the Insured, up to the Maximum Benefit Amount shown in the Insured's Schedule of Benefits: (a) against all risks of permanent loss, theft or damage to the Insured's Baggage and Personal Effects; (b) subject to all General Exclusions and the Additional Limitations and Exclusions Specific to Baggage and Personal Effects in the Insured's Certificate; and (c) occurring while coverage is in effect. For the purposes of this benefit: "Baggage and Personal Effects" means goods being used by the Insured during the Insured's Trip**.**

Valuation and Payment of Loss: The lesser of the following amounts will be paid:

1) the Actual Cash Value at the time of loss, theft or damage, except as provided below;

2) the cost to repair or replace the article with material of a like kind and quality; or

3) $300 per article.

For claimed items without original receipts, payment of loss will be calculated based upon 75% of the Actual Cash Value at the time of loss, not to exceed $300 per article. The

Company may take all or part of a damaged Baggage as a condition for payment of loss. In the event of a loss to a pair or set of items, the Company will:

1) repair or replace any part to restore the pair or set to its value before the loss; or

2) pay the difference between the value of the property before and after the loss.

A combined maximum of $1,000 will be paid for jewelry; precious or semi-precious stones; watches; articles consisting in whole or in part of silver, gold or platinum; furs or articles trimmed with fur; cameras and their accessories and related equipment , computer, digital or electronic equipment or media.

A maximum of $100 will be paid for the cost of replacing a passport or visa.

A maximum of $100 will be paid for the cost associated with the unauthorized use or replacement of lost or stolen credit cards, subject to verification that the Insured has complied with all conditions of the credit card company.

Baggage and Personal Effects does not include:

1) animals;
2) automobiles and automobile equipment;
3) boats or other vehicles or conveyances;
4) trailers;
5) motors;
6) aircraft;
7) bicycles, except when checked as baggage with a Common Carrier;
8) household effects and furnishings;
9) antiques and collectors items;
10) contact lenses, artificial teeth, dentures, dental bridges, retainers;
11) artificial limbs or other prosthetic devices;
12) prescribed medications;
13) keys, money, stamps and credit cards (except as otherwise specifically covered herein);
14) securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
15) professional or occupational equipment or property, whether or not electronic business equipment with the exception of Personal Diving Equipment or
16) sporting equipment if the loss results from the use thereof;

Baggage Delay: If, while on a Trip, the Insured's checked baggage is delayed or misdirected by a Common Carrier for more than 24 hours from the Insured's time of arrival at a destination other than the Insured's return destination, benefits will be paid, up to the Maximum Benefit Amount shown in the Insured's Schedule of Benefits, for the actual expenditure for necessary personal effects. The Insured must be a ticketed passenger on a Common Carrier. The Common Carrier must certify the delay or misdirection. Receipts for the purchases must accompany any claim.

Additional Limitations and Exclusions Specific to Baggage and Personal Effects:

Benefits are not payable for any loss caused by or resulting from:

a) breakage of brittle or fragile articles;
b) wear and tear or gradual deterioration;
c) confiscation or appropriation by order of any government or custom's rule;
d) theft or pilferage while left in any unlocked vehicle;
e) property illegally acquired, kept, stored or transported;
f) the Insured's negligent acts or omissions; or
g) property shipped as freight or shipped prior to the Scheduled Departure Date;
h) electrical current, including electric arcing that damages or destroys electrical devices or appliances.

Additional Provisions applicable to Baggage and Personal Effects and Baggage Delay:

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically scheduled under any other insurance.

Additional Claims Provisions Specific to Baggage

Insured's Duties After Loss of or Damage to Property or Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and Insured must:

a) take all reasonable steps to protect, save or recover the property:

b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of the Insured's property at the time of loss:

c) produce records needed to verify the claim and its amount, and permit copies to be made:

d) send proof of loss as soon as reasonably possible after date of loss, providing date, time, and cause of loss, and a complete list of damaged/lost items: and

e) allow the Company to examine baggage or personal effects, if requested.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate**.**

NON-MEDICAL EMERGENCY EVACUATION

This Non-Medical Emergency Evacuation Benefit is not available if a formal recommendation in the form of a Travel Advisory or Travel Warning from the U.S. State Department is issued for a country preceding the Insured's arrival into that country on the Insured's Trip, or if a country is an Excluded Country preceding the Insured's arrival into that country on the Insured's Trip.

The Insured is eligible for benefits, up to the Maximum Benefit Amount shown in the Confirmation of Benefits, for all reasonable expenses incurred for the Insured's transportation to the nearest place of safety, or to the Insured's primary place of residence, if the Insured must leave the Insured's Trip for a Non-Medical Emergency Evacuation Covered Reason, as defined below.

Non-Medical Emergency Evacuation must occur within 14 days of any covered event. Arrangements will be by the most appropriate and economical means available and consistent with the Insured's health and safety. Benefits are only payable for arrangements made by the travel assistance service provider.

Non-Medical Emergency Evacuation Covered Reasons: The Company will pay for the Non-Medical Emergency Evacuation Benefits listed above if, while on the Insured's Trip, a formal recommendation in the form of a Travel Advisory or Travel Warning from the U.S. State Department, is issued for the Insured to leave a country the Insured is visiting on the Insured's Trip due to:

1) a Natural Disaster;
2) civil, military or political unrest; or
3) the Insured being expelled or declared a persona non-grata by a country the Insured is visiting on the Insured's Trip.

Non-Medical Emergency Evacuation Exclusions: The Company does not cover:

1) loss or expense for a Non-Medical Emergency Evacuation Covered Reason which took place in an Excluded Country;
2) loss or expense recoverable under any other insurance or through an employer;
3) loss or expense arising from or attributable to:

(a) fraudulent or criminal acts committed or attempted by the Insured;

(b) alleged violation of the laws of the country the Insured is visiting, unless the Company determines such allegations to be fraudulent, or

(c) failure to maintain required documents or visas;

4) loss or expense arising from or attributable to:

(a) debt, insolvency, business or commercial failure;

(b) the repossession of any property; or

(c) The Insured's non-compliance with a contract, license or permit;

5) loss or expense arising from or due to liability assumed by the Insured under any contract.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate**.**

24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT

The Company will pay the percentage of the Principal Sum shown in the Table of Losses below when the Insured, as a result of an Injury occurring during the Insured's Trip sustains a loss shown in the Table of Losses below. The loss must occur within one hundred eighty one (181) days after the date of the Injury causing the loss. The Principal Sum is the Maximum Benefit Amount shown in the Schedule of Benefits.

Table of Losses	
Type of Loss	**Benefit Amount**
Loss of Life	100% of Principal Sum
Loss of both hands	100% of Principal Sum
Loss of both feet	100% of Principal Sum
Loss of both eyes	100% of Principal Sum
Loss of one hand and one foot	100% of Principal Sum
Loss of one hand and one eye	100% of Principal Sum
Loss of one foot and one eye	100% of Principal Sum
Loss of one hand	50% of Principal Sum
Loss of one foot	50% of Principal Sum
Loss of one eye	50% of Principal Sum
Loss of thumb and index finger of the same hand	25% of Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing One Ear Both Ears	50% of the Principal Sum

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively.

Loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof.

"Loss of Speech" means the loss of the ability to talk or speak as a result of a Covered Accident. The loss must be certified by a Legally Qualified Physician that the loss of speech is permanent with no reasonable expectation of recovery.

"Loss of Hearing" means the total and complete loss of the ability to hear any sound as a result of a Covered Accident. The loss must be certified by a Legally Qualified Physician that the loss of hearing is permanent with no reasonable expectation of recovery.

Only one of the amounts shown above (the largest applicable) will be paid for Injuries resulting from one accident.

The benefit for loss of: (a) two limbs; (b) both eyes; or (c) one limb and one eye is payable only when such loss results from the same accident.

The Principal Sum is shown in the Insured's Schedule of Benefits.

EXPOSURE AND DISAPPEARANCE

The Company will pay benefits for covered losses that result from the Insured being unavoidably exposed to the elements because of a Covered Accident occurring during the Insured's Trip. The loss must occur within 365 days after the event that caused the exposure.

If, while insured under this Coverage, the Insured is unavoidably exposed to the elements because of a Covered Accident and suffers a loss for which benefits are payable under this Coverage, such loss will be covered.

If, while insured under this Coverage, the Insured is in an Accident resulting in the disappearance, sinking or damaging of an air or water conveyance on which the Insured is covered by this Coverage, and if the Insured's body has not been found within 52 weeks from the date of the Accident, it will be presumed, unless there is evidence to the contrary, that the Insured suffered loss of life as a result of those Injuries.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate**.**

ACCIDENT & SICKNESS MEDICAL EXPENSE

Benefits will be paid for the Covered Expense incurred, up to the Maximum Benefit Amount shown in the Schedule of Benefits, as a result of a Covered Accidental Injury or covered Sickness, which first occurs during the Insured's Trip (of a duration of 90 days or less for Sickness). Only Covered Expenses incurred during the Insured's Trip (of a duration of 90 days or less for Sickness) will be reimbursed. Expenses incurred after the Insured's Trip are not covered.

Benefits will include up to $750 for expenses incurred during the Insured's Trip for emergency dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during the Insured's Trip will be reimbursed. Expenses incurred after the Insured's Trip are not covered.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure the Insured's admission to a Hospital, because of a Covered Accidental Injury or covered Sickness. The authorized travel assistance company will coordinate advance payment to the Hospital.

For the purpose of this benefit:

"Covered Expense" means expense incurred only for the following:

1. The medical services, prescription drugs, prosthetics, and therapeutic services and supplies ordered or prescribed by a Legally Qualified Physician as Medically Necessary for treatment;
2. Hospital or ambulatory medical-surgical center services (including expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Trip, if recommended as a substitute for a hospital room for recovery from a Covered Accidental Injury or covered Sickness);
3. Transportation furnished by a professional ambulance company to and/or from a Hospital**.**

These benefits will not duplicate any benefits payable under the Certificate or any coverage(s) attached to the Certificate**.**

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When the Insured suffers loss of life for any reason or incurs a Sickness or Injury during the course of the Insured's Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Insured's Schedule of Benefits.

1. Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

If the Insured is traveling alone and will be hospitalized for more than 3 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, chosen by the Insured, by Economy Transportation, for a single visit to and from the Insured's bedside.

If the Insured is in the Hospital for more than 3 consecutive days and the Insured's dependent children who are under 18 years of age and accompanying the Insured on the Insured's Trip are left unattended, Economy Transportation will be paid to return the dependents to their home (with an attendant, if considered necessary by the authorized travel assistance company).

2. Medical Repatriation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for the Insured to return to the Insured's primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for the Insured's return to the Insured's primary place of residence or to a Hospital or medical facility closest to the Insured's primary place of place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:

i) one-way Economy Transportation;

ii) commercial air upgrade (to Business or First Class), based on the Insured's condition as recommended by the local attending Legally Qualified Physician and verified in writing and considered necessary by the authorized travel assistance company; or

iii) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.

3. Return of Remains: In the event of the Insured's death during a Trip, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of the Insured's remains to the Insured's primary place of residence in the United States of America or to the place of burial.

If benefits are payable and the Insured has other insurance that may provide benefits for this same loss, the Company reserves the right to recover from such other insurance. The Insured shall:

a) notify the Company of any other insurance;

b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;

c) not do anything after the loss to prejudice the Company's rights; and

d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

Dispatch of a Physician: If the local attending Legally Qualified Physician and the authorized travel assistance company cannot adequately assess the Insured's need for Medical Evacuation or Transportation, and a Physician is dispatched by the authorized travel assistance company to make such assessment, benefits will be paid for the travel expenses incurred and medical services provided by the dispatched Physician.

These benefits will not duplicate any other benefits payable under the Insured's Certificate or any coverage(s) attached to the Insured's Certificate.

SECTION II. DEFINITIONS

"Accident" means a sudden, unexpected unusual specific event that occurs at an identifiable time and place, and shall also include exposure resulting from a mishap to a conveyance in which the Insured is traveling.

"Actual Cash Value" means current replacement cost for items of like kind and quality.

"Additional Transportation Cost" means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.

"Air Carrier" means any air conveyance operating under a valid license for the transportation of passengers for hire.

"Baggage and Personal Effects" means luggage, personal possessions and travel documents taken by the Insured on the Insured's Trip.

"Bankruptcy or Default" means the total cessation of operations due to insolvency, with or without the filing of a bankruptcy petition by an airline, or cruise line, tour operator or other travel provider provided the Bankruptcy or Default occurs more than 14 days following the Insured's Effective Date for the Trip Cancellation Benefits. There is no coverage for the Bankruptcy or Default of any person, organization, agency or firm from whom the Insured purchased Travel Arrangements supplied by others.

"Coinsurance" means the amount of Usual and Customary Charges for which the Insured is responsible for a specified coverage.

"Common Carrier" means any land, sea, or air conveyance operating under a valid license for the transportation of passengers for hire, not including taxicabs or rented, leased or privately owned motor vehicles.

"Complications of Pregnancy" means conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include nonelective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

"Covered Accident" means an Accident that occurs while coverage is in force and results in a loss for which benefits are payable.

"Covered Vehicle" means a private passenger vehicle (including mini-vans, pickup trucks and sport utility vehicles) owned by or under long term lease (1 year or more) to the Insured.

"Deductible" means the dollar amount of expenses which must be incurred and paid by the Insured before benefits are payable under this Policy. It applies separately to each Insured.

"Dive/Diving" means recreational snorkeling or scuba diving, dive training or diving as a scuba instructor, dive master, underwater photographer or while performing research under the auspices and following the diving safety guidelines of the American Academy of Underwater Scientists. A Dive begins upon entry into the water and ends upon exit from the water. A Dive must occur in an area in which snorkeling and/or scuba diving is not prohibited. In the case of scuba Diving, the Insured must be equipped with Personal Diving Equipment. Diving must be done by a person (a) At least 10 years of age and qualified as a diver; the holder of a valid diver's certificate (recognized by international diving organizations); and according to the generally accepted standards of the diving community or (b) who is in the process of obtaining his/her qualification as a diver and is under the supervision of and diving with a qualified diving instructor affiliated with a certifying organization or agency.

"Diving Vacation" means: a vacation spent: (1) in a location at least 50 miles away from the Insured's city of residence, (2) in a Diving resort or Diving facility and/or specifically includes Diving.

"Economy Transportation" means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Insured purchased for the Insured's Trip.

"Elective Treatment and Procedures" means any medical treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

"Excluded Country" means one of the following countries from which Non-Medical Emergency Evacuations are not available such as Afghanistan Chechnya Democratic Republic of the Congo Iran Iraq Israel West Bank Israel Gaza Strip Ivory Coast Lebanon Libya North Korea Somalia Sudan Syria or any country subject to the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSET CONTROLS (OFAC);

"Family Member" means any of the following: the Insured or the Insured's Traveling Companion's legal spouse (or common-law spouse where legal), legal guardian or ward, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, Domestic Partner, Caregiver, or Child Caregiver.

"Home" means the Insured's primary place of residence.

"Hospital" means (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located: (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; (d) other than a residence, a place where treatment in a Hyperbaric chamber can be received. Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Inclement Weather" means any weather condition that delays the scheduled arrival or departure of a Common an Air Carrier.

"Injury" or "Injuries" means bodily harm and/or decompression illness caused by an Accident which: 1) occurs while the Insured's coverage is in effect under the Insured's Certificate; and 2) requires examination and treatment by a Legally Qualified Physician. The Injury must be the direct cause of loss and must be independent of all other causes and must not be caused by, or result from, Sickness.

"Insured Plan Participant" means a person(s) who is eligible for Travel Protection Insurance as a result of being booked to travel on a Trip, completes the enrollment form and for whom the required premium is paid.

"Intoxicated" mean a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Insured is located at the time of an incident.

"Legally Qualified Physician" means a physician or a Christian Science Practitioner: (a) other than the Insured, a Traveling Companion or a Family Member; (b) practicing within the scope of his or her license; and (c) recognized as a physician in the place where the services are rendered.

"Maximum Benefit Amount" means the maximum amount payable for coverage provided to the Insured as shown in the Insured's Schedule of Benefits.

"Medically Fit to Travel" means based on assessment a Legally Qualified Physician has advised the Insured, a Traveling Companion, Family Member or Business Partner booked to travel with the Insured in writing that there is no medical condition, illness, Injury or Sickness that would likely interfere with a Trip at the time of purchase of Coverage for a Trip**.**

"Medically Necessary" means a service which is appropriate and consistent with the treatment of the condition in accordance with accepted standards of community practice.

"Medical Treatment" means examination and treatment by a Legally Qualified Physician for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment.

"**Natural Disaster**" means a flood, hurricane, tornado, earthquake, mudslide, tsunami, avalanche, landslide, volcanic eruption, fire, wildfire or blizzard that is due to natural causes.

"Partial Hospitalization" means an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization. Partial hospital programs are usually furnished by a hospital as distinct and organized intensive ambulatory treatment service of less than 24-hour daily care.

"Payments or Deposits" means the cash, check, or credit card amounts, actually paid for the Insured's Trip. Certificates, vouchers, discounts, credits, frequent traveler or frequent flyer rewards, miles or points applied (in part or in full) towards the cost of the Insured's Travel Arrangements are not Payments or Deposits as defined herein.

"Penalty" means a fee assessed for canceling a reservation. For airline tickets, the cancellation penalty is usually collected by refunding only a portion of the ticket price. For hotel reservations, the cancellation penalty is charged to the credit card or deposit used to secure the reservation.

"**Personal Diving Equipment**" means: 1. Diving equipment, the Insured's property or property in the Insured's control, which feeds compressed or enriched gas; 2. Floating balance; 3. Rapid release buckle on the Diving appliance; 4. Belt and on the weights; 5. Instrument to measure time and to measure depth (one per couple), 6. Warning instrument showing depletion of gas in the tank, and 7. Diving computer and diving gear.

"Pre-Existing Condition" means an illness, disease, or other condition during the 180 day period immediately prior to the date the Insured's coverage is effective for which the Insured or the Insured's Traveling Companion, Business Partner or Family Member scheduled or booked to travel with the Insured: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 180 day period before coverage is effective under the Insured's Certificate**.**

"Prepaid" means Payments or Deposits paid by the Insured to a Travel Supplier for Travel Arrangements for the Insured's Trip prior to the Insured's actual or Scheduled Departure Date. Payments or Deposits for shore excursions, theater, concert or event tickets or fees, or sightseeing, if such arrangements are made during the Insured's Trip and are to be used prior to the Scheduled Return Date of the Insured's Trip, are not considered Prepaid as defined herein.

"Published Penalties" means any additional published cancellation penalties levied by the Insured's travel agency or travel supplier that apply to all clients of the travel agency or travel supplier and can be documented at time of the Insured's purchase of Travel Arrangements from the Insured's travel agency. The maximum amount reimbursable for travel agency published penalties is 25% of the total trip cost excluding taxes and other non-commissionable items.

"Scheduled Departure Date" means the date on which the Insured is originally scheduled to leave on the Insured's Trip.

"Scheduled Return Date" means the date on which the Insured is originally scheduled to return to the point of origin or the original final destination of the Insured's Trip.

"Sickness" means an illness or disease of the body which: 1) requires examination and treatment by a Legally Qualified Physician, and 2) commences while the Insured's coverage is in effect. An illness or disease of the body which first manifests itself and then worsens or becomes acute prior to the Effective Date of the Insured's coverage is not a Sickness and is considered a Pre-Existing Condition as defined herein and is not covered by the Insured's Certificate**.**

"Strike" means any organized and legally sanctioned labor disagreement resulting in a stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased; and (b) which interferes with the normal departure and arrival of a Common an Air Carrier.

"Terrorist Incident" means an act of violence, that is deemed terrorism by the United States Government other than civil disorder or riot (that is not an act of war, declared or undeclared) that results in loss of life or major damage to property, by any person acting alone or in association with other persons on behalf of or in connection with any organization of foreign government which is generally recognized as having the intent to overthrow or influence the control of any other foreign government. The Terrorist Incident must be documented in a Travel Warning issued by the United States' Department of State advising Americans to avoid that certain country.

"Third Party" means a person or entity other than the Insured or the Company.

"Transportation Expense" means the cost of Medically Necessary conveyance, personnel, and services or supplies.

"Travel Advisory or Travel Warning" means U.S. State Department communication advising caution in traveling to specified destinations due to reasons such as armed violence, civil or political unrest, high incidence of crime (specially kidnapping and/or murder), natural disaster or outbreak of one or more contagious diseases.

"Traveling Companion" means a person or persons whose names appear with the Insured's on the same Travel Arrangements and who, during the Insured's Trip, will accompany the Insured. A group or tour organizer, sponsor or leader is not a Traveling Companion as defined, unless sharing accommodations in the same room, cabin, condominium unit, apartment unit or other lodging with the Insured.

"Travel Supplier" means any entity or organization that coordinates or supplies travel services for the Insured**.**

"Trip" means a scheduled trip for which coverage for Travel Arrangements is requested and the premium is paid prior to the Insured's actual or Scheduled Departure Date of the Insured's Trip a scheduled trip of 90 days or less and a trip of 50 miles or more from the Insured's primary residence for which coverage is requested and the premium is paid.

"Usual and Customary Charges" means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not payable for any loss due to, arising or resulting from:

1. an act of declared or undeclared war;
2. participating in maneuvers or training exercises of an armed service, except while participating in weekend or summer training for the reserve forces of the United States, including the National Guard;
3. being Intoxicated as defined herein, or under the influence of any controlled substance unless as administered or prescribed by a Legally Qualified Physician;
4. the commission of or attempt to commit a felony or being engaged in an illegal occupation;
5. normal childbirth or pregnancy (except Complications of Pregnancy) or voluntarily induced abortion;
6. dental treatment (except as coverage is otherwise specifically provided herein);
7. amounts which exceed the Maximum Benefit Amount for each coverage as shown in the Insured's Schedule of Benefits;
8. due to a Pre-Existing Condition, as defined in the Insured's Certificate. The Pre-Existing Condition Limitation does not apply to the Emergency Medical Evacuation or Return of Remains coverage;
9. any amount paid or payable under any Worker's Compensation, Disability Benefit or similar law;
10. a loss or damage caused by detention, confiscation or destruction by customs;
11. Elective Treatment and Procedures;
12. Complications from Elective Treatment and Procedures otherwise not payable under the Insured's Certificate;
13. medical treatment during or arising from a Trip undertaken for the purpose or intent of securing medical treatment;
14. failure of any tour operator, Common Carrier, or other travel supplier, person or agency to provide the bargained-for travel arrangements for reasons other than Bankruptcy or Default;
15. a mental or nervous condition, unless hospitalized or Partially Hospitalized for that condition while the Insured's Certificate **is** in effect for the Insured;
16. a loss that results from an illness, disease or other condition, event or circumstance which occurs at a time when the Insured's Certificate is not in effect for the Insured;
17. Bankruptcy or Default or failure to supply services by a supplier of travel services.
18. due to loss or damage (including death or injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.
19. Diving while in an abnormal state of which the Insured was aware and/or due to which the Insured was disqualified or not entitled to engage in Diving;
20. Diving in an area where Diving is forbidden.
21. an assessment from a Legally Qualified Physician advising the Insured in writing that the Insured, a Traveling Companion, Family Member or Business Partner booked to travel with the Insured are not Medically Fit to Travel, as defined in the Certificate, at the time of purchase of Coverage for a Trip.
22. Your arrival into a country for which a formal recommendation in the form of a Travel Advisory or Travel Warning from the U.S. State Department has been issued preceding Your arrival into that country on Your Trip, or if a country is an Excluded Country preceding Your arrival into that country on Your Trip.

PRE-EXISTING CONDITION EXCLUSION:
The Company will not pay for any expense as a result of any illness, disease, or other condition during the 180 day period immediately prior to the date the Insured's coverage is effective for which the Insured or Insured's Traveling Companion, Business Partner or Family Member scheduled or booked to travel with the Insured: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this Exclusion does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 180 day period before coverage is effective under this Policy.

EXCESS INSURANCE LIMITATION:
The insurance provided by the Insured's Certificate shall be in excess of all other valid and collectible Insurance or Indemnity. If at the time of the occurrence of any loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity, and applicable deductible. Recovery of losses from other parties does not result in a refund of premium paid.

SECTION IV. TERMINATION OF POLICY

The Policyholder or the Company may terminate the Policy by giving 31 days advanced written notice to the other party. Termination is without prejudice to any claims that exist on such date**.**

SECTION V. CLAIM PROVISIONS

Notice of Claim: Notice of claim must be reported within 20 days after a loss occurs or as soon as is reasonably possible. You or someone on Your behalf may give the notice. The notice should be given to Us or Our designated representative and should include sufficient information to identify You.

Claim Forms: When notice of claim is received by Us or Our designated representative, forms for filing proof of loss will be furnished. If these forms are not sent within 15 days, the proof of loss requirements can be met by You sending Us a written statement of what happened. This statement must be received within the time given for filing proof of loss.

Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

Time of Payment of Claims: We, or Our designated representative, will pay the claim after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life will be paid to Your designated beneficiary. If a beneficiary is not otherwise designated by You, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

a) Your spouse;
b) Your child or children jointly;
c) Your parents jointly if both are living or the surviving parent if only one survives;
d) Your brothers and sisters jointly; or
e) Your estate.

All other Benefits will be paid directly to You, unless otherwise directed. Any accrued benefits unpaid at Your death will be paid to Your estate. If You have assigned Your benefits, we will honor the assignment if a signed copy has been filed with us. We are not responsible for the validity of any assignment.

All or a portion of all benefits provided by the Certificate may, at Our option, be paid directly to the provider of the service(s) to You. All benefits not paid to the provider will be paid to You.

If any benefit is payable to: (a) an Insured who is a minor or otherwise not able to give a valid release; or (b) the Insured's estate, We may pay up to $1,000 any amount due under the Certificate to the Insured's beneficiary or any relative whom We find entitled to the payment. Any payment made in good faith shall fully discharge Us to any party to the extent of such payment.

Subrogation: If the Company has made a payment for a loss under the Insured's Certificate, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right. The Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event the Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss.

SECTION VI. GENERAL PROVISIONS

The Contract: The entire contract is made up of the Policy, the Policyholder's Application, a copy of which is attached, the Participation Agreement, a copy of which is attached, the Certificates of
Insurance, and the individual enrollment forms of the Insureds. This Policy may be changed, renewed, or ended without notice to or consent of any person with a beneficial interest in this Policy.

Limit on Agent's Authority: No agent may change or waive any provisions of this Policy. Our officer must approve any change or waiver in writing.

Certificates: The Company may issue certificates to the Insureds. Such certificates will describe each person's benefits and rights under this Policy.

Data Needed: The Policyholder or its agent will keep a record of all the data needed to compute premiums and carry out the terms of this Policy. The Company may examine such data at any reasonable time.

Clerical Error: A clerical error may be made by the Company or the Policyholder in keeping the data. If so, when the error is found, the premium and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in force, nor will it continue insurance validly ended.

Policy Non-Participating: This Policy does not pay dividends.

Agency: The Policyholder is not the agent of the Company for any purpose under this Policy.

Legal Actions: All policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action for a claim may be brought against Us after 3 years from the time written Proof of Loss is required to be furnished.

Concealment and Misrepresentation: The entire coverage will be void, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

Other Insurance with the Company: You may be covered under only one travel Certificate with the Company for each Trip. If You are covered under more than one such Certificate, You may select the coverage that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. Premiums paid (less claims paid) will be refunded for the duplicate coverage that does not remain in effect.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

CALIFORNIA AMENDATORY ENDORSEMENT

This Amendatory Endorsement is attached to and made a part of Policy Number US1221836 issued to the Policyholder.

This Amendatory Endorsement is attached to and made a part of the Certificate issued to the Insured. The provisions of this Amendatory Endorsement are effective on the Effective Date and will expire concurrently with the Certificate, unless otherwise terminated.

The Policy/Certificate are hereby amended for **California** as follows:

1. The **Non-Medical Emergency Evacuation Exclusions** provision appearing in **NON-MEDICAL EMERGENCY EVACUATION** is deleted and replaced as follows:

Non-Medical Emergency Evacuation Exclusions: We do not cover:

1) loss or expense for a Non-Medical Emergency Evacuation Covered Reason which took place in an Excluded Country;

2) loss or expense recoverable under any other insurance or through an employer;

3) loss or expense arising from or attributable to:

(a) fraudulent or felony criminal acts committed or attempted by You;

(b) alleged violation of the laws of the country You are visiting, unless We determine such allegations to be fraudulent, or

(c) failure to maintain required documents or visas;

4) loss or expense arising from or attributable to:

(a) debt, insolvency, business or commercial failure;

(b) the repossession of any property; or

(c) Your non-compliance with a contract, license or permit;

5) loss or expense arising from or due to liability assumed by You under any contract.

2. The Who is Eligible for Coverage provision appearing in SECTION III. INSURING PROVISIONS of the Certificate is deleted and replaced with the following:

   Who is Eligible for Coverage:
   A citizen or resident of the United States of America who is booked to travel on Your Trip and for whom the required premium is paid.

3. The **Time of Payment of Claims** provision appearing in **Section V. GENERAL PROVISIONS** is deleted and replaced as follows:

   Time of Payment of Claims: Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof.

4. The **Entire Contract** provision is added to in **Section V. GENERAL PROVISIONS**:

   Entire Contract: The entire contract is made up of the Policy, the Application, the Certificates of Insurance, and the individual enrollment forms of the Insureds. Any statement made by the insured shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any insured whose eligibility has been accepted by the insurer shall be used in defense to a claim hereunder. No agent may change the Policy or Certificate of Insurance in any way. Only an officer of the Company can approve a change. Any such change must be shown in the Policy or its attachments

If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Amendatory Endorsement will govern.

Signed for **United States Fire Insurance Company** By:

Signed for **United States Fire Insurance Company** By:

Marc J. Adee
Chairman and CEO

James Kraus
Secretary

California Guaranty Notice

NOTICE OF PROTECTION PROVIDED BY THE CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protection provided to policyholders by the California Life and Health Insurance Guarantee Association ("the 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. Insurance Companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The valuable extra protection provided through the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and he amounts of coverage.

Below is a brief summary of the coverages, exclusions, and limit provided by the Association. 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

- **Persons Covered**

Generally, an individual is covered by the California Life and Health Insurance Guarantee Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuity Benefits

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**

  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- **Annuities and Structured Settlement Annuities**

  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of polices or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract;
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- If the person is provided coverage by the guaranty association of another state;
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual;
- Employer and association plans, to the extent they are self-funded or uninsured;
- A policy or contract providing any health care benefits under Medicare Part C or Part D;
- An annuity issued by an organization that is only licensed to issue charitable gift annuities;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

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

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: [5 Christopher Way • Eatontown, NJ 07724]

WRITTEN NOTICE TO CALIFORNIA RESIDENTS REGARDING TRAVEL INSURANCE PURCHASE

NOTICE: This plan contains disability insurance benefits or health insurance benefits, or both, that only apply during the covered trip. You may have coverage from other sources that already provides you with these benefits. You should review your existing policies. If you have any questions about your current coverage, call your insurer or health plan.

When used throughout this document "Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:
(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:
(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;

(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey 07724

Disclosure Notice:

This plan provides insurance coverage that only applies during the covered trip. You may have coverage from other sources that provides you with similar benefits but may be subject to different restrictions depending upon your other coverages. You may wish to compare the terms of this policy with your existing life, health, home, and automobile insurance policies. If you have any questions about your current coverage, call your insurer or insurance agent or broker.

Purchasing travel insurance is not required in order to purchase any other products or services offered by the Travel Retailer.

What A Travel Retailer May Do:
Employees of a Travel Retailer may transact Travel Insurance on our behalf and under our direction, including:

1. Offering/disseminating information on our behalf, including brochures, buyer guides, descriptions of coverage, and price;
2. Referring specific coverage/feature/benefit questions to us;
3. Disseminating/processing applications for coverage, coverage selection forms, or other similar forms;
4. Collecting premiums on our behalf;
5. Receiving/recording information to share with us;

What A Travel Retailer May Not Do:
The Travel Retailer's employees:

1. are not qualified or authorized to answer technical questions about the benefits, exclusions or conditions of any of the insurance offered by the Travel Retailer; or
2. to evaluate the adequacy of a prospective insured's existing insurance coverage.

Definitions

"Travel Insurance" means coverage for personal risks incidental to planned travel, including one or more of the following:

Interruption or cancellation of a trip or event;
Loss of baggage or personal effects;
Damage to accommodations or rental vehicles; or
Sickness, accident, disability, or death occurring during travel.

The following are excluded from the definition of Travel Insurance: Major medical plans, which provide comprehensive medical protection for travelers on trips lasting 6 months or longer (e.g. working overseas, deployed military personnel, etc.). In some States, Damage waiver contracts that are part of a rental company's agreement. The phrase "damage waiver" or "collision damage waiver" cannot be used to describe travel insurance coverage, but the travel insurance contract may otherwise refer to "damage waiver" or "collision damage waiver" provided by a rental company.

"We, Us or Our" means Specialty Insurance Solutions.

DISCLOSURE TO CALIFORNIA RESIDENTS: [1754(a)(7) & (8)]

1. Purchasing travel insurance is not required in order to purchase any other product or service offered by the travel retailer.
2. Your travel retailer may not be licensed to sell insurance, and is therefore not qualified or authorized to:

    a. Answer technical questions about the benefits, exclusions, and conditions of any of the insurance offered by the travel retailer.
    b. Evaluate the adequacy of your existing insurance coverage.

This plan provides insurance coverage that only applies during the covered trip. You may have coverage from other sources that provide you with similar benefits but may be subject to different restrictions depending upon your other coverages. You may wish to compare the terms of this policy with your existing life, health, home and automobile insurance policies. If you have any questions about your current coverage, call your insurer or insurance agent or broker.

DISCLOSURE TO DELAWARE RESIDENTS: [1772(2)a.7.]

The insurance coverage may duplicate existing coverages you may have. You may wish to compare the terms of this policy with your existing life, health, home and automobile policies, and other sources of protection.

DISCLOSURE TO MARYLAND RESIDENTS: [10-122 (d)(1)(ii)(4)]

This insurance coverage may duplicate certain provisions of insurance coverage already provided by your homeowner's, renter's or similar coverages or insurances, and that the purchase of travel insurance would make travel insurance primary to any other duplicate or similar coverage.