

LOUISIANA



Gap ER PlanSM
Member Driven **Value.**
Group Insurance Certificates



*These Group Insurance Certificates are for the Gap ER PlanSM **purchased on or after 090717**. If you purchased the Gap ER PlanSM **prior to 090717**, your group insurance certificates may be different. You can call your personal member concierge at 866.438.4274 to get your correct certificates.*

Catlin Insurance Company, Inc.
Statutory Home Office: 2800 Post Oak Blvd., Suite 4050,
Houston, TX 77056
Administrative Office: 3340 Peachtree Road N.E., Suite
2950, Atlanta, GA 30326
A Stock Insurance Company

GROUP ACCIDENT CERTIFICATE

THIS CERTIFICATE IS A QUALIFIED GROUP ACCIDENT INSURANCE CONTRACT

Certifies that the Insured is covered under the Policy issued to the Policyholder.

"We", "Our" and "Us" are used to refer to the Catlin Insurance Company, Inc.

This certificate is not the Policy. It is evidence of the Member's coverage under the Policy. Coverage is subject to the Policy provisions. The Policy was issued to the Policyholder. The Member may inspect the Policy at the Policyholder's office during normal business hours.

CAUTION: If the Member has misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

A copy of the application is attached to this certificate. The best time to clear up any questions is now, before a claim arises. If you have any questions contact Us at this address:

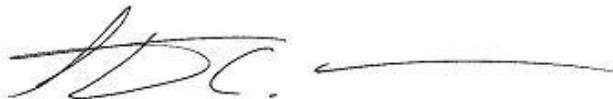
Catlin Insurance Company, Inc.
c/o Health Special Risk, Inc.
P.O. Box 117086
Carrollton, Texas 75011

This Certificate describes the terms and conditions of insurance. The laws of the State of Issue govern the Policy.

10-DAY RIGHT TO EXAMINE AND RETURN THIS CONTRACT

Please read this Contract. If this Contract was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements, you may return the Contract within 10 days after you received it. Any premium paid will be refunded. This Contract will then be void from its start.

Signed for Catlin Insurance Company, Inc. at its Home Office, 1330 Post Oak Boulevard, Suite 2325, Houston, Texas 77056.



Secretary



President

Countersigned _____
Where Required By Law

EFFECTIVE DATE AND TERM

The Policy starts on the Policy Effective Date. The Covered Person's coverage starts on the Covered Person's Effective Date stated in the Certificate Identification. It stays in-force for the period for which the Covered Person's premium has been paid.

The Covered Person's coverage may be continued in force, as provided in the Continuation of Insurance clause. If the Policy is not renewed or the Covered Person is no longer eligible for coverage the Covered Person's coverage will cease at the termination date provided we give at least 60 days written notice of termination.

CERTIFICATE IDENTIFICATION

POLICYHOLDER:	United Business Association
POLICY NUMBER:	GAH-022 FD8-1000000
POLICY EFFECTIVE DATE:	July 4, 2013
POLICY ANNIVERSARY DATE:	July 4
STATE OF ISSUE:	Louisiana
CERTIFICATE NUMBER:	00000000000

(PLEASE NOTE THAT THIS SCHEDULE PAGE REPLACES ANY SCHEDULE PAGE PREVIOUSLY ISSUED TO YOU)

SCHEDULE OF BENEFITS

Covered Classes

All active Members and enrolled Spouses and Dependent Children of the Policyholder
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Time Period for Loss

Any Covered Loss must occur within:	365 days of the Covered Accident
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This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Member Principal Sum:	\$1,000
Spouse Principal Sum:	\$1,000
Dependent Child(ren) Principal Sum:	\$1,000

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .
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ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

EMERGENCY TREATMENT BENEFIT	
Benefit Amount	\$1,000 per visit
Maximum Number of Visits	5 per year

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GENERAL DEFINITIONS

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

Active Service	<p>A Member will be considered in Active Service with the Policyholder on any day on which the Member meets all the conditions of membership of the Policyholder.</p> <p>An eligible Dependent Child or eligible Spouse of the Member is considered in Active Service if he is none of the following:</p> <ol style="list-style-type: none">1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;2. Confined at home under the care of Physician for Sickness or Injury;3. Totally Disabled.
Aircraft	<p>A vehicle which:</p> <ol style="list-style-type: none">1. has a valid certificate of airworthiness; and2. is being flown by a pilot with a valid license to operate the Aircraft.
Certificate	<p>The Certificate is not the Policy and is evidence of the Member's coverage under the Policy. Coverage is subject to the Policy provisions.</p>
Complications of Pregnancy	<p>Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include: false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.</p>
Core Plan	<p>The noncontributory plan of benefits provided under the Policy.</p>
Covered Accident	<p>A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:</p> <ol style="list-style-type: none">1. occurs while the Covered Person is insured under the Policy;2. is not contributed to by disease, Sickness, mental or bodily infirmity;3. is not otherwise excluded under the terms of the Policy.
Covered Injury	<p>Any bodily harm that results directly and independently of all other causes from a Covered Accident.</p>
Covered Loss	<p>A loss that is all of the following:</p> <ol style="list-style-type: none">1. the result, directly and independently of all other causes, of a Covered Accident;2. one of the Covered Losses specified in the Schedule of Covered Losses;3. suffered by the Covered Person within the applicable time period specified in the <i>Schedule of Benefits</i>.
Covered Person	<p>An eligible person in a covered class, as shown in the Schedule of</p>

Benefits: for whom an enrollment form has been accepted by Us; and required premium has been paid when due; and for whom coverage under the Policy remains in force. The term Covered Person shall include, where the Policy provides coverage, an eligible Spouse and eligible Dependent Children.

Dependent Child(ren)

A Member's unmarried child:

1. from live birth to 26 years old; or
2. chiefly dependent on the Member and incapable of self-sustaining employment. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

A child, for purposes of this provision, includes an Member's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Member;
4. grandchild who is in the legal custody of the grandparent Member;
5. child who is placed in the home of an Member following execution of an act of voluntary surrender in favor of the Member or the Member's legal representative, effective on the date on which the act of voluntary surrender becomes irrevocable;
6. child for whom the Member is legal guardian, as long as the child resides with the Member and depends on the Member for financial support. Financial support means that the Member is eligible to claim the dependent for purposes of Federal and State income tax returns.

If a Member who is the legal guardian of a child is not a step-parent, aunt or uncle, then the child must have resided with the Member for at least twelve six consecutive months and intend to reside with the Member for an indefinite period of time.

Domestic Partners

A person of the same or opposite sex who:

1. shares the covered Member's permanent residence;
2. has resided with the covered Member continuously for at least six months and is expected to reside with the covered Member indefinitely;
3. Is financially interdependent with the covered Member in each of the following ways:
 - a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
 - b. by owning or leasing their permanent residence as joint tenants;
 - c. by naming, or being named by, the covered Member as a beneficiary of life insurance or under a will;
 - d. by each agreeing in writing to assume financial responsibility for the welfare of the other;
4. has signed a Domestic Partner declaration with the covered Member, if the covered Member resides in a jurisdiction which provides for a Domestic Partner declaration;
5. has not signed a Domestic Partner declaration with any other person within the last 12 months;
6. is no less than any Age from 18 years not more than 70 years of age;
7. is not legally permitted to marry the covered Member;
8. is not legally married to any other person;

9. is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.

A covered Member may insure a Domestic Partner if all of the following conditions are met:

1. the covered Member has not been married to any person within the past 12 months;
2. the Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the covered Member;
3. The covered Member and the Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.

Effective Date

The date on which insurance under the Policy begins as shown in the Schedule of Benefits.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

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

Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.

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

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

Insured

A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.

Member

For eligibility purposes, a Member is a person who meets all of the conditions of membership of a Policyholder.

and who is a United States citizen or has a permanent alien registration card and who is in one of the Covered Classes.

Physician

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

1. employed or retained by the Policyholder;

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

Policy	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.
Policyholder	The entity to which the Policy is issued and will include any affiliate or subsidiaries or divisions shown in the "Eligibility for Insurance" section.
Schedule of Benefits	A brief outline of the coverage and benefits provided by this Policy.
Sickness	A physical or mental illness including pregnancy. Complications of pregnancy are considered a Sickness.
Spouse*	The Member's lawful spouse.
*The term Spouse includes a Domestic Partner as defined.	
Termination Date	The date on which insurance ends as defined later in this Policy.
Terrorism or Terrorist Act	Any hostile or violent act carried out by a group of persons having political or military goals but not operating on behalf of a foreign state and whose purpose is to compel an act or omission by any other person or governmental entity.
Totally Disabled or Total Disability	Totally Disabled or Total Disability means either: <ol style="list-style-type: none"> 1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of: education; training; or experience; or 2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including: eating; transferring; dressing; toileting; bathing; and continence;, without human supervision or assistance.
We, Us, Our	Catlin Insurance Company, Inc.
You, Your	The Member to whom the certificate is issued.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Policy Effective Date

The Insurance Company agrees to provide Accident Insurance Benefits described in the Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage for the Policyholder begins on the Policy Effective Date shown on the Policy's first page.

Eligibility

A Member becomes eligible for insurance under the Policy on the date: he meets all of the requirements of one of the covered classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* and is insured under the Core Plan. A Spouse and Dependent Children of an eligible Member become eligible for any dependent insurance provided by the Policy on the later of: the date the Member becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of the Policy. No person may be eligible for insurance under the Policy as both a Member and a Spouse or Dependent Child at the same time.

A Member whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the first day of the month coinciding with or next following the date of the change.

Effective Date for Individuals

Insurance becomes effective for an eligible Member on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. the date the Member becomes eligible;
3. the date We receive and accept the Member's completed enrollment form during his lifetime.

We may, from time to time, require the Member to re-enroll using forms supplied by Us to keep his insurance in force.

Insurance becomes effective for a Member's eligible Dependent Children on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. the date the Member's insurance becomes effective;
3. the date the Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
4. the date We receive the Member's completed enrollment form for Spouse and Dependent Child coverage, during each Dependent Child's lifetime.

Newborn Children: A Member's newborn child is automatically covered from the moment of birth until such child is 31 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The Member must notify the Company in writing within 31 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 31 day period.

Adopted Children: An adopted child is automatically covered for the first 31 days from: the date of placement for the purpose of adoption; or the date of the entry of an order granting the adoptive parent custody of the child if all other eligible children are covered under the certificate prior to: the date of placement; or date of the entry. Coverage for such child will be the same as for all other covered Dependent Children. The Member must: notify the Company in writing within 31 days of: the date of placement; or the date of the entry; and pay the required additional premium (if any); in order to have coverage for the adopted child continue beyond such 31 day period.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by the Policy; or
2. a change in the Member's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE

The insurance on a Covered Person will end, with at least 60 days written notice, on the earliest date below:

1. the date the Policy or insurance for a covered class is terminated;
2. the date the Policyholder's coverage under the Policy ends;
3. the next premium due date after the date the Covered Person is no longer in a covered class or satisfies eligibility requirements under the Policy;
4. the last day of the last period for which premium is paid;
5. with respect to a Spouse or Dependent Child, the date of the death of the covered Member. See *Continuation of Insurance* section;
6. the date that the plan of benefits under which the Covered Person is covered is terminated.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

CONTINUATION OF INSURANCE

Insurance for the covered Spouse and Dependent Children may be continued if a covered Spouse's and Dependent Children's insurance would otherwise end because of death of or divorce from the covered Member. The Covered Spouse must:

1. submit a written request for continued insurance to Us within 31 days of the event; and
2. pay the required premium to the Policyholder, directly to Us.

Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last 6 months.

Any Continuation of Insurance is subject to Our continuing to offer insurance under the Policy to new applicants.

COMMON EXCLUSIONS

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

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony the Covered Person's being engaged in an illegal occupation;
3. commission of or active participation in: a riot; insurrection; or Terrorist Act;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. Terrorism or Terrorist Acts;
7. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
 - a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
 - b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
 - c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;
8. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
9. participation in any motorized race or contest of speed;
10. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
11. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence, including malpractice;
12. travel in any Aircraft owned; leased; or controlled by the Policyholder; or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
13. the Covered Person's intoxication;
14. the Covered Person's being under the influence of narcotics, unless administered on the advice of a Physician;
15. injuries compensable under: Workers' Compensation law; or any similar law;
16. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.

CLAIM PROVISIONS

Notice of Claim

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

Claim Forms

We will send claim forms for filing proof of loss when We receive notice of a claim. Such forms will be the standard forms prescribed by the state for health and accident claims, including the UB-82 form or its successor, and the HCFA Form 1500 or its successor. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

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

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by the Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under the Policy.

Time of Payment of Claims

We will pay benefits due under the Policy for any loss other than a loss for which the Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

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

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

Physical Examination and Autopsy

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

Legal Actions

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

Beneficiary

The beneficiary is the person or persons the Member names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by the Policy. A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the Member's Spouse or Dependent Child.

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

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

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

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

Recovery of Overpayment

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

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

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

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advance written notice to the Policyholder. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 6 month period. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the terms of the Policyholder's participation change;
3. a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
4. there is a change in the factors bearing on the risk assumed;
5. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Payment of Premium

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

If any premium is not paid on the Premium Due Date when due, the Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period section.

Grace Period

1. Policy

A Policy Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force. Whenever We do not receive a premium payment fifteen days prior to the end of the grace period, We will mail, by first class mail, a notice to the Insured. The notice shall state that if the premium has not been paid by the end of the grace period, the Policy will lapse as provided by the provisions of the Policy. The notice shall also state that the Policy will be reinstated with no penalties whatsoever to the Insured if the full premium payment is received within the period allowed for reinstatement.

GENERAL PROVISIONS

Entire Contract; Changes

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

Misstatement of Fact

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

Certificates

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of the Policy. It will state to whom benefits will be paid.

Multiple Certificates

The Covered Person may have in force only one certificate at a time under the Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment

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

Incontestability

1. Of The Policy or Participation Under The Policy

All statements made by the Policyholder to obtain the Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of the Policy or of participation under the Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After three years from the Policy Effective Date, no such statement will cause the Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

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

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

We may terminate coverage on or after the first anniversary of the policy effective date. The Policyholder may terminate coverage on any premium due date. Written or authorized electronic notice must be given at least 60 days prior to such premium due date. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Reinstatement

The Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Clerical Error

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

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to the Policy are automatically changed to satisfy the minimum requirements of such laws. If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Policy Changes

We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

Workers' Compensation Insurance

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

Examination of the Policy

This Policy will be available for inspection at the Policyholder's office during regular business hours.

Examination of Records

We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Accident Coverages and Benefits provided by the Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within the Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms; conditions; and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss

resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions

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

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

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

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

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

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

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

Exclusions

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

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE

Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within 1 year from the date of: the wrecking; sinking; or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under the Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions

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

RIDER: AHAG 404 (LA) 0712
POLICY HOLDER: United Business Association
POLICY NUMBER: GAH-022 FD8-1000000
POLICY EFFECTIVE DATE: July 4, 2013
POLICY ANNIVERSARY DATE: July 4
POLICY TERM: July 4, 2013 until cancellation
STATE OF ISSUANCE: Louisiana
RIDER EFFECTIVE DATE: September 1, 2016

EMERGENCY TREATMENT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment by a Physician in a Hospital Emergency Room subject to the Maximum Number of Visit in the *Schedule of Benefits*.

Definition For purposes of this benefit:
Emergency Room means a trauma center or a special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician’s office.

Exclusions For purposes of this benefit:
In addition to the General Exclusions stated in the Policy, We will not cover charges under this Rider for:

1. Hernia, however caused;
2. Services or treatment provided by a family member or the Covered Person;
3. Cosmetic surgery or procedures;
4. Any loss to which a contributing cause was the Covered Person’s being engaged in any illegal occupation or activity;
5. Pregnancy or childbirth

The President and Secretary of Catlin Insurance Company, Inc. witness this Rider.



President

Secretary

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

A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, LA 70804

Department of Insurance
P.O. Box 94212
Baton Rouge, LA 70804-9214

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

C. Coverage. Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

D. Exclusions from Coverage

1. However, persons holding such policies are not protected by this association, if:
 - a. they are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state.);

- b. the insurer was not authorized to do business in this state;
 - c. their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
2. The association also does not provide coverage for:
- a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
 - b. any policy of reinsurance (unless an assumption certificate was issued);
 - c. interest rate yields that exceed an average rate;
 - d. dividends;
 - e. credits given in connection with the administration of a policy by a group contract holder;
 - f. employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
 - g. unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under § 403(b) of the Internal Revenue Code, except that, even if qualified under § 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

E. Limits on Amounts of Coverage

1. The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Catlin Insurance Company, Inc.

Statutory Home Office: 1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056

Administrative Office: 3340 Peachtree Road N.E., Suite 2950, Atlanta, GA 30326

A Stock Company

RIDER:

POLICY HOLDER: United Business Association
POLICY NUMBER: GAH-022 FD8-1000000
POLICY EFFECTIVE DATE: July 4, 2013
POLICY ANNIVERSARY DATE: July 4
POLICY TERM: July 4, 2013 until cancellation
STATE OF ISSUANCE: Louisiana
RIDER EFFECTIVE DATE: July 1, 2016

CRITICAL ILLNESS COVERAGE RIDER

1. The following is added to the Schedule of Benefits:

Critical Illness Coverage	
Benefit Amount	\$7,150
Invasive Cancer	100% of the Maximum Benefit Amount
Heart Attack (Myocardial Infarction)	100% of the Maximum Benefit Amount
Stroke	100% of the Maximum Benefit Amount

2. We will pay the benefit shown in the Schedule of Benefits:

1. if the Covered Person is diagnosed for the first time by a Physician as having a Covered Condition and the diagnosis is made while the Coverage is in force; and
2. if the Covered Condition is not a Pre-Existing Condition; and
3. if the Covered Condition is first diagnosed after 365 days from the Covered Person's effective date; and
4. if none of the exclusions or limitations described in the Coverage or Policy apply; and
5. if the Covered Person survives for a period of not less than 0 days after the first diagnosis of a covered Critical Illness.
6. if the Covered Person signs up for coverage prior to Age 65.
7. if the Covered Person is less than Age 70.
8. If the Covered Condition is first diagnosed within 365 days from the Covered Person's coverage effective date, We will pay \$715.

The benefit amount will be reduced as described below:

1. when the Covered Person reaches Age 60, the benefit amount will be reduced by 50%.

The following conditions are payable under this benefit rider. If a condition is not shown below, no benefits will be paid for that illness.

1. **Invasive Cancer** – is a malignant neoplasm (including lymphatic and hematological malignancy) characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. This does not include:
 1. Kaposi's Sarcoma or other Acquired Immune Deficiency Syndrome (AIDS) related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV);
 2. Skin cancer or melanoma that is not invasive and less than 2.1 mm Breslow Thickness;
 3. All tumours of prostate unless the Gleason score is greater than 6 or having progressed to at least clinical TNM classification T2 N0 M0;
 4. Cancer in situ;
 5. Carcinoid of the appendix;
 6. Stage 0 transitional carcinoma of the urinary bladder; or
 7. Any other pre-malignant lesions, benign tumors, or polyps.

Invasive Cancer must be diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on microscopic examination of fixed tissues or preparations from the hemic system. Such diagnosis shall be based solely on the accepted criteria

of malignancy, after a study of the histocytologic architecture or pattern of the suspected tumor, tissue, and/or specimen. Clinical Diagnosis of Invasive Cancer will be accepted as evidence that Invasive Cancer exists when a Pathological Diagnosis cannot be made, provided the medical evidence substantially documents the Clinical Diagnosis of Invasive Cancer and the Covered Person receives treatment for Invasive Cancer.

2. **Heart Attack (Myocardial Infarction)** – is the death of a portion of the heart muscle as a result of inadequate blood supply. To receive benefits under this illness, the Diagnosis of the heart attack must be made by a Physician board certified as a Cardiologist. The Diagnosis must be supported by all of the following:
 - a. new EKG changes demonstrating significant Q waves (duration greater than or equal to .04 seconds and a depth greater than or equal to 5 mm) or loss of R waves diagnostic of a heart attack;
 - b. The rise of cardiac enzymes or Troponins to the following levels
 - i. Troponin T greater than 1.0 ng/ml
 - ii. AccuTnl greater than 0.5 ng/ml or equivalent threshold with other Troponin I methodsThe evidence must show a definite acute myocardial infarction and;
 - c. if performed, nuclear imaging scan or echocardiogram consistent with a heart attack.

This does not include all other heart disorders, including but not limited to: an EKG change consistent with transient ischemic change, chance find of EKG changes suggestive of a previous Heart Attack, the death of the heart muscle coincidental with death from other causes; congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, and all other dysfunctions of the cardiovascular system, unless also accompanied by a heart attack as defined above.

3. **Stroke** – is:
 - a. a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours; and
 - b. a resulting measurable neurological deficit persisting for at least 30 days after the occurrence of the stroke.

Diagnosis of stroke must be made by a neurologist based on documented neurological deficits and confirmatory neuroimaging studies.

For the purposes of this definition, Stroke does not mean:

- a. Transient Ischemic Attacks (TIAs);
- b. Neurological symptoms due to transient ischemic attack (TIA).
- c. Transient Global Amnesia;
- d. Vertebro-Basilar Insufficiency; Incidental findings on imaging studies;
- e. Brain injuries resulting from trauma or generalized anoxia (hypoxia); or
- f. Vascular disease affecting the eye, optic nerve, or vestibular function.

Definition For purposes of this rider:

Clinical Diagnosis means a clinical identification of Invasive Cancer or In-Situ Cancer based on history, laboratory study and symptoms.

Covered Condition means any of the coverages listed under the Schedule of Benefits for this Rider.

Diagnosis means the definitive establishment, acceptable to us, of the condition listed in this benefit rider through the use of clinical and/or laboratory findings and subject to the terms and conditions of the coverage. The Diagnosis must be made by a Physician who is a board-certified specialist where required under the terms of the coverage.

We reserve the right to request a Physician of our choice to review any Critical Illness diagnosis in the event of a dispute or disagreement regarding the appropriateness or correctness of such diagnosis. We reserve the right to require the Covered Person to submit to an examination to confirm a disputed diagnosis. We also reserve the right to

request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed diagnosis. We will pay for any such requested examination or review.

Pathological Diagnosis means an identification of cancer based on a microscopic study of fixed tissue or preparations from the hemi(blood) system.

Pre-existing Condition(s) means a condition for which medical advice, Diagnosis, care or treatment was recommended or received within 6 the month period before the Covered Person's coverage effective date. A Pre-Existing Condition is excluded from coverage for period of 6 months following the Covered Person's coverage effective date. If the Covered Person is Diagnosed with a condition listed in this rider that is determined to be a Pre-Existing Condition, no benefit amount is payable for that listed condition. We may have the Covered Person examined by a Physician of Our choosing at Our expense.

Waiting Period means the continuous period of time beginning on the later of the Covered Person's coverage effective date or the reinstatement date, and ending 365 days from the Covered Person's effective date. The Covered Person must be covered continuously under this benefit rider before the benefit amount may be payable and the condition must first occur after the Waiting Period. If the Covered Person's condition first occurs during the Waiting Period, no benefits will be payable, the benefit will terminate, and We will refund to the Covered Person all premiums paid for this benefit without interest.

A condition shall be considered to have first occurred when symptoms or laboratory and/or clinical findings that lead to the Diagnosis of a condition are first documented in the Covered Person's medical records regardless of the date upon which the Diagnosis is actually made.

Exclusions

In addition to the Common Exclusions listed in the Policy, no benefits will be paid for:

1. Benign tumors or polyps that are histological described as non-malignant, pre-malignant or non-invasive.
2. All tumors, benign or malignant, in the presence of HIV infection.
3. All skin cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of 0.75 mm.
4. All tumors of the prostate, unless having progressed to at least TNM classification T2N0M0 or histological classified as having a Gleason score greater than 6.
5. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater.
6. Papillary micro invasive cancer of the thyroid, bladder, cervix or breast.
7. Participation in the commission or attempted commission of a felony.
8. Voluntary participation in a riot or insurrection.
9. Refusing certain types of recommended medical treatment as follows:
 - a. A Physician has recommended treatment with angioplasty or coronary artery bypass graft for coronary artery disease, the Covered Person refuses this treatment, and the Covered Person suffers a heart attack.
 - b. A Physician has recommended treatment for a brain aneurysm or carotid artery stenosis, the Covered Person refuses treatment, and the Covered Person suffers a stroke.
 - c. A Physician has recommended a diagnostic biopsy or diagnostic/therapeutic excision of a mass or lesion suspected of being cancerous, the Covered Person refuses, and the Covered Person develops cancer.
10. Conditions that have not been Diagnosed by a Physician.
11. Conditions that were diagnosed after the benefit rider has been terminated.
12. If the Covered Person's date of birth or age was misstated on the application and, using the correct date of birth or age, the benefit would not have become effective or would have terminated prior to Diagnosis of a listed condition.
13. Pre-existing Conditions.

Payment of Benefits

In addition to the policy claim provisions, payment of the benefit amount is subject to all of the following conditions:

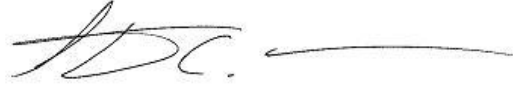
1. The sum of the benefit amounts payable under this benefit rider and any other Critical Illness policy and Critical Illness policies issued by Us on the life of the Covered Person may not exceed \$100,000.

2. If the Covered Person dies within 365 days of the first diagnosis of a covered Critical Illness, no Critical Illness benefits are payable.
3. Only one benefit payment is allowed during the lifetime of the Covered Person, as defined by the terms and conditions of this benefit rider. After the payment is made to the Covered Person, this benefit will terminate for that particular Covered Person only.

The President and Secretary of Catlin Insurance Company, Inc witness this Rider.



President



Secretary

NOTICE TO POLICYHOLDERS

FRAUD NOTICE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC PROVISIONS

- Arkansas** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- Colorado** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- District of Columbia** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- Florida** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- Hawaii** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
- Kentucky** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- Louisiana** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- Maine** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
- Maryland** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- New Jersey** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO POLICYHOLDERS

New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York

All commercial insurance forms, except as provided for automobile insurance:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Automobile insurance forms

Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

Fire Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:

- A.** The misinformation is material to the content of the policy;
- B.** We relied upon the misinformation; and
- C.** The information was either:
 - 1.** Material to the risk assumed by us; or
 - 2.** Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests.

With regard to fire insurance, in order to trigger the right to remedy, material misrepresentations must be willful or intentional.

Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

NOTICE TO POLICYHOLDERS

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Auto: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to \$15,000.

Puerto Rico

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning the possible impact on your insurance coverage provided under your policy due to directives issued by OFAC. Please read this Policyholder Notice carefully.

OFAC administers and enforces economic and trade sanctions based on US foreign policy and national security goals based on Presidential declarations of "national emergency." OFAC has identified and listed numerous:

- Foreign agents
- Front organizations
- Terrorists
- Terrorist organizations
- Narcotics traffickers

as "Specially Designated Nationals and Blocked Persons." This list can be found on the United States Treasury's web site – <http://www.treas.gov/ofac>.

In accordance with OFAC regulations, if it is determined that you or any other insured, or any person or entity claiming the benefits of this insurance has violated US sanctions law or is a Specially Designated National and Blocked Person, as identified by OFAC, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments may also apply.

NOTICE TO POLICYHOLDERS

PRIVACY POLICY

Catlin insurance group [the “Companies”], believes personal information that we collect about our customers, potential customers, and proposed insureds [referred to collectively in this Privacy Policy as “customers”] must be treated with the highest degree of confidentiality. For this reason and in compliance with the Title V of the Gramm-Leach-Bliley Act [“GLBA”], we have developed a Privacy Policy that applies to all of our companies. For purposes of our Privacy Policy, the term “personal information” includes all information we obtain about a customer and maintain in a personally identifiable way. In order to assure the confidentiality of the personal information we collect and in order to comply with applicable laws, all individuals with access to personal information about our customers are required to follow this policy.

Our Privacy Promise

Your privacy and the confidentiality of your business records are important to us. Information and the analysis of information is essential to the business of insurance and critical to our ability to provide to you excellent, cost-effective service and products. We understand that gaining and keeping your trust depends upon the security and integrity of our records concerning you. Accordingly, we promise that:

1. We will follow strict standards of security and confidentiality to protect any information you share with us or information that we receive about you;
2. We will verify and exchange information regarding your credit and financial status only for the purposes of underwriting, policy administration, or risk management and only with reputable references and clearinghouse services;
3. We will not collect and use information about you and your business other than the minimum amount of information necessary to advise you about and deliver to you excellent service and products and to administer our business;
4. We will train our employees to handle information about you or your business in a secure and confidential manner and only permit employees authorized to use such information to have access to such information;
5. We will not disclose information about you or your business to any organization outside the Catlin insurance group of Companies or to third party service providers unless we disclose to you our intent to do so or we are required to do so by law;
6. We will not disclose medical information about you, your employees, or any claimants under any policy of insurance, unless you provide us with written authorization to do so, or unless the disclosure is for any specific business exception provided in the law;
7. We will attempt, with your help, to keep our records regarding you and your business complete and accurate, and will advise you how and where to access your account information [unless prohibited by law], and will advise you how to correct errors or make changes to that information; and
8. We will audit and assess our operations, personnel and third party service providers to assure that your privacy is respected.

Collection and Sources of Information

We collect from a customer or potential customer only the personal information that is necessary for [a] determining eligibility for the product or service sought by the customer, [b] administering the product or service obtained, and [c] advising the customer about our products and services. The information we collect generally comes from the following sources:

Submission – During the submission process, you provide us with information about you and your business, such as your name, address, phone number, e-mail address, and other types of personal identification information;

Quotes – We collect information to enable us to determine your eligibility for the particular insurance product and to determine the cost of such insurance to you. The information we collect will vary with the type of insurance you seek;

NOTICE TO POLICYHOLDERS

Transactions – We will maintain records of all transactions with us, our affiliates, and our third party service providers, including your insurance coverage selections, premiums, billing and payment information, claims history, and other information related to your account;

Claims – If you obtain insurance from us, we will maintain records related to any claims that may be made under your policies. The investigation of a claim necessarily involves collection of a broad range of information about many issues, some of which does not directly involve you. We will share with you any facts that we collect about your claim unless we are prohibited by law from doing so. The process of claim investigation, evaluation, and settlement also involves, however, the collection of advice, opinions, and comments from many people, including attorneys and experts, to aid the claim specialist in determining how best to handle your claim. In order to protect the legal and transactional confidentiality and privileges associated with such opinions, comments and advice, we will not disclose this information to you; and

Credit and Financial Reports – We may receive information about you and your business regarding your credit. We use this information to verify information you provide during the submission and quote processes and to help underwrite and provide to you the most accurate and cost-effective insurance quote we can provide.

Retention and Correction of Personal Information

We retain personal information only as long as required by our business practices and applicable law. If we become aware that an item of personal information may be materially inaccurate, we will make reasonable effort to re-verify its accuracy and correct any error as appropriate.

Storage of Personal Information

We have in place safeguards to protect data and paper files containing personal information.

Sharing/Disclosing of Personal Information

We maintain procedures to assure that we do not share personal information with an unaffiliated third party for marketing purposes unless such sharing is permitted by law. Personal information may be disclosed to an unaffiliated third party for necessary servicing of the product or service or for other normal business transactions as permitted by law.

We do not disclose personal information to an unaffiliated third party for servicing purposes or joint marketing purposes unless a contract containing a confidentiality/non-disclosure provision has been signed by us and the third party. Unless a consumer consents, we do not disclose “consumer credit report” type information obtained from an application or a credit report regarding a customer who applies for a financial product to any unaffiliated third party for the purpose of serving as a factor in establishing a consumer’s eligibility for credit, insurance or employment. “Consumer credit report type information” means such things as net worth, credit worthiness, lifestyle information [piloting, skydiving, etc.] solvency, etc. We also do not disclose to any unaffiliated third party a policy or account number for use in marketing. We may share with our affiliated companies information that relates to our experience and transactions with the customer.

Policy for Personal Information Relating to Nonpublic Personal Health Information

We do not disclose nonpublic personal health information about a customer unless an authorization is obtained from the customer whose nonpublic personal information is sought to be disclosed. However, an authorization shall not be prohibited, restricted or required for the disclosure of certain insurance functions, including, but not limited to, claims administration, claims adjustment and management, detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity, underwriting, policy placement or issuance, loss control and/or auditing.

Access to Your Information

NOTICE TO POLICYHOLDERS

Our employees, employees of our affiliated companies, and third party service providers will have access to information we collect about you and your business as is necessary to effect transactions with you. We may also disclose information about you to the following categories of person or entities:

Your independent insurance agent or broker;

An independent claim adjuster or investigator, or an attorney or expert involved in the claim;

Persons or organizations that conduct scientific studies, including actuaries and accountants;

An insurance support organization;

Another insurer if to prevent fraud or to properly underwrite a risk;

A state insurance department or other governmental agency, if required by federal, state or local laws; or

Any persons entitled to receive information as ordered by a summons, court order, search warrant, or subpoena.

Violation of the Privacy Policy

Any person violating the Privacy Policy will be subject to discipline, up to and including termination.

For more information or to address questions regarding this privacy statement, please contact your broker.