

Certificate of Insurance



ZURICH[®]

ZURICH AMERICAN INSURANCE COMPANY

Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 8365008 to cover the eligible individuals of:

The Aerospace Corporation

The insurance evidenced by this **Certificate** provides **ACCIDENT** insurance only. It does not provide **Coverage** for sickness. This **Certificate** describes the main features of the **Policy**, but the **Policy** is the only contract under which benefit payments are made. If there is an inconsistency between the **Certificate** and the **Policy**, the **Policy** will govern.

IMPORTANT NOTICE

**THIS INSURANCE PROVIDES ACCIDENT COVERAGE ONLY
THIS INSURANCE DOES NOT PROVIDE BENEFITS FOR SICKNESS**

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SECTION I – ELIGIBILITY AND EFFECTIVE DATES

CERTIFICATEHOLDER:

Class I: All regular and temporary employees (excluding Casual employees and Retirees), of the **Policyholder**, who work at least 20 hours a week. Regular employees are those who work on a regularly scheduled and assigned basis, either full-time or part-time. Temporary employees are those who work no more than 12 months.

Note: If **You** suffer an **Injury** resulting in a **Covered Loss** and **You** are covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF YOUR DEPENDENTS:

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

YOUR EFFECTIVE DATE OF INSURANCE:

- A. For eligible individuals hired prior to January 1, 2023:
January 1, 2023, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.
- B. For eligible individuals hired on or after January 1, 2023:
On the first day of the month following completion of the required **Service Waiting Period** indicated above, provided the completed enrollment material is received by the **Policyholder** prior thereto.

SECTION II – SCHEDULE

COVERAGES(S):

Classes Covered

24 Hour Accident Protection, Business and Pleasure, Including Corporate Owned or Leased Aircraft, H-1	All
Exposure and Disappearance Coverage	All
War Risk Coverage	All

BENEFITS:

Classes Covered

ACCIDENTAL DEATH BENEFIT Principal Sum:	All
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Class I: **You** may purchase an amount of **Principal Sum** from a minimum of \$10,000 to a maximum of \$600,000 in increments of \$10,000. However, amounts applied for in excess of \$300,000 must not exceed ten (10) times **Your Base Annual Earnings***.

Coverage is extended to properly licensed eligible employee pilots for their elected **Principal Sum**, subject to a maximum of \$100,000.

* **Base Annual Earnings** means **Your** annual pay excluding overtime, bonuses or any other remuneration arising out of employment with the **Policyholder**. With respect **You** paid on an hourly basis, **Base Annual Earnings** means **Your** hourly rate times the number of hours in **Your** normal working year, but not to exceed 2,080 hours per year.

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

<u>Plan Selected</u>	<u>% Spouse/Domestic Partner</u>	<u>% Child(ren)</u>
Spouse/Domestic Partner only:	100%	0%
Dependent Child(ren) only:	0%	15%
Spouse/Domestic Partner and Dependent Child(ren)	80%	15%

Maximum of \$50,000 **Principal Sum Accidental Death Benefit** for **Dependent Child(ren)**.

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

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

Classes Covered

ACCIDENTAL DISMEMBERMENT BENEFIT

Principal Sum

Same as above.

Coma Benefit

Permanent and Total Disability Benefit

All

All

All

ADDITIONAL BENEFITS:

Common Disaster Benefit

Continuation of Insurance Benefit

Day Care Benefit

Higher Education Benefit

Home Alteration and Vehicle Modification Benefit

Rehabilitation Benefit

Spouse/Domestic Partner Retraining Benefit

Travel Assistance Plan

Classes Covered

All

All

All

All

All

All

All

All

ADDITIONAL ENDORSEMENTS

Form Number

Classes Covered

Safety Device Benefit

U-VA-113-A (CW) (02/09)

All

SECTION III – DEFINITIONS

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

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

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

Certificate means this **Certificate** for the **Group Accident Insurance Policy**.

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

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

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

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

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

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

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You** and **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)**.

Dependent means **Your Spouse/Domestic Partner** and **Dependent Child(ren)**, as defined in this section. The **Dependent** will only be a **Covered Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren), if used in the **Policy**, means **Your** unmarried **Child(ren)** and, those unmarried **Child(ren)** of **Your** legally married **Spouse**, and those unmarried **Child(ren)** as defined in the **Policyholder's** medical plan as on file and approved by **Us** of **Your Domestic Partner** who rely on **You** for more than 50% of their support, and are either: 1) less than nineteen (19) years of age; 2) less than twenty-six (26) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Domestic Partner means as defined in the **Policyholder's** medical plan as on file and approved by **Us**.

Injury means a bodily **Injury**.

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

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

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

Policy means the Group **Accident** Insurance **Policy**.

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

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

acrobatic or stunt flying	hang gliding
banner towing	hunting
bird or fowl herding	parachuting or skydiving
crop dusting	pipe line inspection
crop seeding	power line inspection
crop spraying	racing
endurance tests	skywriting
exploration	test or experimental purpose
fire fighting	
flight on a rocket-propelled or rocket launched aircraft	

Spouse, if used in the **Policy**, means **Your** legally married **Spouse**. **Your Spouse** will only be a **Covered Spouse** if a **Plan** covering **Your Spouse** is selected.

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

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

You, Your refers to the **Insured**.

SECTION IV – COVERAGES

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

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

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

Hazard Limitations:

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

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

1. medical certificate; and
 2. pilot certificate with a proper rating to pilot such aircraft
- B.** any aircraft which is operated by the Armed Forces of the United States of American or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

- A.** If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft. Or
- B.** Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
1. any aircraft other than those expressly stated in this **Coverage**;
 2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder** except the following aircraft:

Any aircraft provided by Twin Otter International

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least N/A hours as a pilot of which at least N/A hours were logged in this or the same class of aircraft.

3. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured**;
4. any aircraft operated by the **Policyholder**;
5. any aircraft engaged in a **Specialized Aviation Activity**;
6. any conveyance except aircraft used for tests or experimental purposes, or in a race or speed test.

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

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

WAR RISK COVERAGE

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section VII General Exclusions of this **Policy** is modified, and **Covered Injuries** directly resulting from war or any acts of war, whether declared or undeclared, are covered under this **Policy** provided:

- A.** the war or act of war causing the **Injury** does not occur within any of the states of the United States of America (including the District of Columbia), Afghanistan, Belarus, Iraq, Russia, Ukraine, or **Your** country of residence.

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

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

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

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

ACCIDENTAL DISMEMBERMENT BENEFIT

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

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

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

For purposes of this benefit:

1. **Covered Loss** means:
 - a. For a foot or hand, actual severance through or above an ankle or wrist joint;
 - b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
 - c. Total and permanent loss of sight;
 - d. Total and permanent loss of speech;
 - e. Total and permanent loss of hearing.

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

COMA BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** will be equal to 1% of the **Covered Person's Principal Sum** and will be paid each month the **Covered Person** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. when the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. when the **Covered Person** has received a **Coma Benefit** for 100 months.

Coma will be determined by **Our** duly licensed physician.

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

PERMANENT AND TOTAL DISABILITY BENEFIT

If **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury** **We** will pay a **Permanent and Total Disability Benefit** provided that **You** become **Permanently and Totally Disabled** within 365 days of the **Injury**; and the **Permanent and Total Disability** continues for twelve (12) months. The benefit payable equals **Your Principal Sum** to a maximum of \$250,000 less any amount payable pursuant to the limitations in Section VIII – General Limitations of this **Policy**.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that **You** are reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the rest of **Your** life.

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

SECTION VI – ADDITIONAL BENEFITS

COMMON DISASTER BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse/Domestic Partner** are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** suffered in the same **Accident** and within ninety (90) days of such **Accident**, the **Principal Sum** that would have been payable because of **Your Covered Spouse's/Domestic Partner's Accidental Death** will be increased to equal that payable for **Your** loss, provided:

1. **You** and **Your Covered Spouse/Domestic Partner** are survived by one or more **Covered Dependent Child(ren)**; and
2. the combined benefits of **You** and **Your Covered Spouse/Domestic Partner** are not more than \$1,200,000.

CONTINUATION OF INSURANCE BENEFIT

If **You**, selected a **Plan** covering **Your Dependents** and **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, all **Coverages** under the **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than **You**, will be continued automatically for 365 days after the date of the loss at no additional cost.

DAY CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse/Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 10% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. \$12,000.

If both **You** and **Your Covered Spouse/Domestic Partner** suffer a simultaneous **Covered Loss**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Covered Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Covered Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

HIGHER EDUCATION BENEFIT

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

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

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

The **Higher Education** will be equal to 5% of **Your Principal Sum**, to a maximum of \$25,000. This amount will be paid annually for four (4) consecutive years if **Your Covered Dependent Child** continues his or her education. Before this benefit is paid each year, **Your Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no **Covered Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of \$1,000 to the designated beneficiary.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

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

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

Benefits will not be payable unless:

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

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Covered Person's Principal Sum** or \$50,000.

REHABILITATION BENEFIT

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

1. the actual expenses that are incurred within [two (2) years] from the date of the **Accident** for the **Rehabilitation Training**;
2. \$25,000; or
3. 10% of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

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

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

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

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

SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT

If **You** selected a **Plan** covering **Your Spouse/Domestic Partner** and **You** suffer an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay to, or on behalf of **Your Covered Spouse/Domestic Partner** the actual cost of any professional or trade-training program in which the **Covered Spouse/Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from **Your** death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payment under this benefit will be \$10,000.

TRAVEL ASSISTANCE PLAN

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

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

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

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

Medical Repatriation

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

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the

transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

Return of Remains

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

Visit to Hospital

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

Return of Child

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

Return of Companion

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

• **TRAVEL ASSISTANCE EXCLUSIONS**

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

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

- **TRAVEL ASSISTANCE DEFINITIONS**

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

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

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

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

“**Principal Residence**” means the legal domicile of the **Covered Person**.

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

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

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

Reservation of Rights

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

Scope

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

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

SECTION VII – GENERAL EXCLUSIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
6. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

SECTION VIII – GENERAL LIMITATIONS

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

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

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

SECTION IX - TERMINATION OF INSURANCE

Your Insurance. **Your** insurance terminates at the end of the date for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;
4. **You** retire.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written **Policy**, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of **Coverage** is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.

Your Covered Dependent's Insurance. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after **Your Covered Dependent** no longer qualifies as a **Covered Person**.

Conversion Privilege

If **Your** insurance ceases for reasons other than termination of the **Policy** or nonpayment of premium, **You** are entitled to convert **Your Coverage** to an **Individual Accidental Death or Dismemberment (IAD)** policy or to a **Family AD&D (FAD)** policy if **You** selected a **Plan** covering **Your Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. **You** must make a written application for the **IAD** or **FAD** policy within thirty-one (31) days of the cessation of **Your** insurance under the Group **Accident Policy**. To request a Conversion Application Form, **You** must call 1-888-634-6780. **You** do not have to show proof of good health.

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

1. The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or \$250,000;
2. The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and
4. When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

The **Conversion Privilege** will cease when **You** attain age 70.

SECTION X - HOW TO FILE A CLAIM

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

- B. Claim Forms.** We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and extent of **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.
- C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss** and the proof was provided as soon as reasonably possible.

SECTION XI - PAYMENT OF CLAIMS

- A. Time of Payment.** We will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.
- B. Who We Will Pay.**
1. **Your Loss of Life.** **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to the beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your** legally married **Spouse** or **Domestic Partner**;
 - b. **Your Child(ren)**;
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
 2. **Loss of Life of Your Covered Dependent.** **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.
 3. **All Other Claims.** Benefits are to be paid to the **Covered Person**.
- C. Physical Examination and Autopsy.** We have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- D. Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

SECTION XII - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.
- B. Change or Waiver.** A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.
- C. Clerical Error.** A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

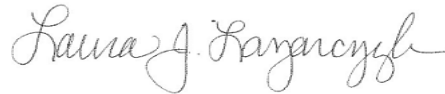
- D. Conformity with Statute.** Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.
- E. Suit Against Us.** No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years , (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- F. Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.
- G. Arbitration.** Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Covered Person**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Covered Person** is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the **Covered Person** from instituting a lawsuit.

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



Kristof Terryn
President

Zurich American Insurance Company



Laura J. Lazarczyk
Corporate Secretary

Zurich American Insurance Company

NON-PARTICIPATING

The Aerospace Corporation
GTU 8365008
Effective: January 1, 2024

Version: November 2023

This endorsement, effective January 1, 2024, forms a part of **Policy No. GTU 8365008**, issued to The Aerospace Corporation.

THIS ENDORSEMENT CHANGES THE CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Group Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Certificate**:

SECTION II – SCHEDULE is amended to include the following:

ADDITIONAL BENEFITS:

Classes Covered

Safety Device Benefit

All

SECTION VI – ADDITIONAL BENEFITS is amended to include the following:

SAFETY DEVICE BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the **Accidental** death directly resulted from an **Accident**, **We** will pay an additional benefit, which equals 10% of the **Insured's Principal Sum** up to a maximum of \$25,000, provided that the **Covered Person** was:

1. operating or riding as a passenger in or on any private passenger automobile, motorcycle, scooter, moped, bicycle, boat or seagoing vessel, sailboard, personal watercraft, all-terrain vehicle, all-terrain cycle, snowmobile or while participating in downhill skiing, snowboarding, horseback riding, water skiing or other towed activities; and
2. wearing or protected by, as per manufacturer's instructions, any of the following:
 - a. an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.
 - b. a manufacturer equipped air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was fastened at the time of the **Accident**.
 - c. an **Approved Personal Flotation Device** while the **Covered Person** is swimming, engaging in water sports or legally operating or riding as a passenger in a boat, seagoing vessel, sailboard or personal watercraft.
 - d. an **Approved Motorcycle Helmet** while the **Covered Person** is operating or riding as a passenger on a motorcycle, scooter, moped, all-terrain vehicle (ATV), or all-terrain cycle (ATC) that is being operated legally per all local and state laws, rules and regulations.
 - e. an **Approved Snowmobile Helmet** while the **Covered Person** is operating or riding as a passenger on a snowmobile that is being operated legally.
 - f. an **Approved Bicycle Helmet**, while the **Covered Person** is legally operating a bicycle.
 - g. an **Approved Ski Helmet** while the **Covered Person** is engaged in downhill skiing or snowboarding, after purchasing a valid lift ticket and skiing/snowboarding during normal operating hours and on the marked premises of the facility selling the lift ticket.

- h. an **Approved Equestrian Helmet** while the **Covered Person** is engaged in horseback riding.
- i. an **Approved Protective Helmet** while the **Covered Person** is actively at work.
- j. **Approved Body Armor** while the **Covered Person** is actively at work.

Verification of the **Covered Person's** actual use of the Safety Device is required as follows:

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

We will not pay a **Safety Device Benefit** if the **Covered Person** was the driver or operator of any private passenger automobile, motorcycle, scooter, moped, bicycle, boat or seagoing vessel, sailboard, personal watercraft, all-terrain vehicle, all-terrain cycle, snowmobile or while participating in downhill skiing, snowboarding, horseback riding, water skiing or other towed activities, if at the time the **Covered Person** was:

- 1. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage; or
- 2. engaged in contests or competitions.

SAFETY DEVICE BENEFIT DEFINITIONS:

Approved Personal Flotation Device (PFD) means a United States Coast Guard approved Type I, II, III or V PFD of appropriate size for the intended user. For water skiing, other towed activities or operation of a personal watercraft a PFD labeled for that activity must be used.

Approved Motorcycle Helmet means a helmet meeting United States Department of Transportation Federal Motor Vehicle Safety Standard (FMVSS) 218 or subsequent standard(s).

Approved Snowmobile Helmet means a helmet meeting the United States Department of Transportation FMVSS 218 or subsequent standard(s).

Approved Bicycle Helmet means a helmet meeting American Society of Testing and Materials (ASTM) standard F1447 or subsequent standard(s).

Approved Ski Helmet means a helmet conforming to Snell Memorial Foundation standards S-98 or RS-98 or ASTM standard F2040 or subsequent standard(s).

Approved Equestrian Helmet means a helmet conforming to Snell Memorial Foundation standard E-2001 or ASTM standard F1163 or subsequent standard(s).

Approved Protective Helmet means a helmet complying with American National Standards Institute (ANSI) standard Z89.1-2003 or subsequent standard(s).

Except for the above, this Amendatory Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. 1



Signed for by Zurich American Insurance Company _____ Date: November 7, 2023

Domestic Partner Endorsement



ZURICH AMERICAN INSURANCE COMPANY
1299 Zurich Way
Schaumburg, Illinois 60196

THIS ENDORSEMENT CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the The Aerospace Corporation Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the Policy/Certificate:

PURPOSE:

California law requires that insurers offer coverage to parties to a domestic partnership that is equivalent to coverage provided to spouses. To that end, California has made certain changes to its law as it relates to domestic partners. This endorsement is part of and amends the policy, contract or certificate to comply with California law.

DEFINITIONS:

The definition of **Domestic Partner** as found in the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached is hereby amended and replaced with the following:

Domestic Partner means a person who qualifies as a domestic partner under the law of the State of California. A domestic partnership is established between the **Domestic Partner** and the **Insured** when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to the California Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the domestic partnership was created.

To be active, the **Insured** will not have completed a Termination of Domestic Partner status form with respect to the **Domestic Partner** who is to be covered under the **Policy**.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE:

California law grants parties to a domestic partnership the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a domestic partnership. For example, the Employee Retirement Income Security Act of 1974, a federal law known as "ERISA" controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a domestic partner in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a domestic partner if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a domestic partnership and their families may or may not have access to certain benefits under the policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under the contract.

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: January 1, 2024

Attached to and forming a part of Policy/Certificate No. GTU 8365008

Signed for Zurich American Insurance Company by: _____

Date: November 7, 2023

Signed for the Policyholder by: _____

Date: _____

This endorsement, effective January 1, 2024, forms a part of **Policy/Certificate** No. GTU 8365008, issued to The Aerospace Corporation.

THIS ENDORSEMENT CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**.

SECTION IX - TERMINATION OF INSURANCE paragraph **A. Policy Termination** is deleted and replaced in its entirety with the following:

SECTION IX - TERMINATION OF INSURANCE

A. Policy Termination.

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

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

Except for the above, this amendatory endorsement does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Signed for by Zurich American Insurance Company



Date: November 7, 2023

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

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association 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 protection provided by 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 the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits 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 or the rights or obligations of the Association.

COVERAGE

• **Persons Covered**

Generally, an individual is covered by the 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 Annuities**

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 policies 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 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)(2)(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

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

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

Advisory notice to policyholders regarding the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC") regulations

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 notice provides information concerning possible impact on your insurance coverage due to directives issued by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

Please read this Notice carefully.

OFAC administers and enforces sanctions policy based on Presidential declarations of "national emergency". OFAC has identified and listed numerous:

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

as "Specially Designated Nationals and Blocked Persons." This list can be located on the United States Treasury's web site – <http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.

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 U.S. 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 are immediately subject to OFAC restrictions. When an insurance policy is considered to be such a blocked or frozen contract, no payments or premium refunds may be made without authorization from OFAC. Other limitations on premiums and payments also apply.



Privacy Notice

We Take Important Steps to Protect the Nonpublic Personal Information We Collect About You

Dear Customer:

rev. January 2020

We care about your privacy. That is why we believe in your right to know what nonpublic personal information (“NPI”) we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
Why are you receiving this Notice?	Financial institutions, which include the Company, choose how they share your NPI. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services.
What types of Information do we collect?	<p>The types of NPI we collect depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none">• Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver’s license number, employment information, information about your income, assets and net worth, and medical information;• Information about your transactions with the Company and its affiliates;• Information about your insurance coverage, premiums, claims history, and payment history;• Data from insurance support organizations, government agencies, insurance information sharing bureaus;• Property information and similar data about you or your property, such as property appraisal reports; and• Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report. <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>
What do we do with the NPI we collect?	<p>We share your NPI in the course of supporting your insurance coverage or non-insurance products or services, as authorized by law, or with your consent. This includes sharing, as permitted by law, your NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products.</p> <p>These affiliates and nonaffiliated third parties include:</p> <ul style="list-style-type: none">• Financial service providers, such as banks and other insurance companies;• Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and• Others, such as consumer reporting agencies and insurance information sharing bureaus.

In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, and whether you can opt out of this sharing (or if you are a resident of Vermont, whether you have the right to opt in to allowing this sharing).

Reasons we can share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
For our everyday business purposes – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
For our marketing purposes - to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	Not Applicable
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	Not Applicable
For our affiliates to market to you	Yes	No
For non-affiliates to market their products to you	No	Not Applicable

Collecting and safeguarding information	
How often do you notify me about your privacy practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. Please review the privacy policy posted on our website, ZurichNA.com. It contains additional information about our practices.
Why do you collect my NPI?	We collect NPI when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What NPI do we share?	We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?"
How do you safeguard my NPI?	Employees who have access to your NPI are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information, you must submit a request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information if it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once through any of the above methods, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW
Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: <ul style="list-style-type: none"> • Processing transactions, mailing and auditing services; • Administering insurance coverage, product, services or claims; • Providing information to credit bureaus; • Protecting against fraud; • Responding to court/governmental orders or subpoenas and legal investigations; and • Responding to insurance regulatory authorities.
Affiliates	Financial or nonfinancial companies related by common ownership or control. <ul style="list-style-type: none"> • <i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i>

Nonaffiliated Third Parties	Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the services. <ul style="list-style-type: none"> • <i>The Company does not share information with nonaffiliates to market their products to you.</i>
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. <ul style="list-style-type: none"> • <i>The Company does not jointly market.</i>

Changes to this Privacy Notice; contact us	<p>We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.</p> <p>If you have any questions about your contract with us, you should contact your agent.</p> <p>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.</p>
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This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the “Company:”

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (together, “the ZNA P&C Companies”), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York.