



**ZURICH**

ZURICH AMERICAN INSURANCE COMPANY  
Schaumburg, Illinois

## **Certificate of Insurance**

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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

**CERTIFICATE HOLDER:** 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.

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

**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.

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 el

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, 2025: January 1, 2025, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For eligible individuals hired on or after January 1, 2025: 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, All Including Corporate Owned or Leased Aircraft, H-1

All

Exposure and Disappearance Coverage

All

War Risk Coverage

All

**BENEFITS:**

**Classes Covered**

**Principal Sum:**

**Class I:**

You may purchase an amount of a **Principal Sum** as elected, of: \$20,000; \$50,000; \$100,000; \$200,000; \$300,000; \$400,000; \$500,000; or \$600,000. A **Principal Sum** above \$300,000 is subject to ten (10) times the employee's **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 the **Your** annual pay excluding overtime, bonuses or any other remuneration arising out of employment with the **Policyholder**. With respect to **Your** paid on an hourly basis, **Base Annual Earnings** means **Your** hourly rate times the number of hours in his or her 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 the **Insured's** previous **Principal Sum** per the following schedule:

<b>AGE AT DATE OF LOSS</b>	<b>PERCENT OF PRINCIPAL SUM</b>
<b>70-74</b>	<b>65%</b>
<b>75-79</b>	<b>45%</b>
<b>80-84</b>	<b>30%</b>
<b>85 &amp; OVER</b>	<b>15%</b>

### Classes Covered

### ACCIDENTAL DISMEMBERMENT BENEFIT

<b>Principal Sum</b>	<b>Classes Covered</b>
Same as Above	All
Coma Benefit	All
Permanent and Total Disability Benefit	All
<b>ADDITIONAL BENEFITS: Classes Covered</b>	
Day Care Benefit	All
Higher Education Benefit	All
Home Alteration and Vehicle Modification Benefit	All
Rehabilitation Benefit	All
Spouse/Domestic Partner Retraining Benefit	All
Travel Assistance Plan	All

<b>ADDITIONAL ENDORSEMENTS</b>	<b>FORM NUMBER</b>	<b>CLASSES COVERED</b>
Safety Device Benefit	U-VA-112-B VA (05/19)	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**.

**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**

**Dependent** means **Your Spouse** and **Dependent Child(ren)**, as defined in this section.

**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.

**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**.

**Spouse**, if used in the **Policy**, means **Your** legally married **Spouse**.

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

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

**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 this **Policy** are:

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

#### **Hazard Limitations:**

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

- A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
  - 1. medical certificate; and
  - 2. pilot certificate with a proper rating to pilot such aircraft.
- B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

#### **Hazard Exclusions:**

**Coverage** is not provided:

- A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft.
- B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
  - 1. any aircraft other than those expressly stated in this **Coverage**;
  - 2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder** 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 person lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

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

#### **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 the **Covered Person's** country of residence.

We may, by giving seven (7) days written notice to the **Policyholder**, (1) require additional premium, to be calculated at the standard war risk rates utilized at the time of the exposure; (2) amend the list of countries above; or (3) cancel this **Coverage**. Any revision or cancellation will not prejudice any claim that occurred prior to the effective date of the revision or cancellation. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. **Our** failure to exercise any of **Our** rights under this **Coverage** will not be deemed a waiver of these rights.

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 **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**.

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

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** is 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. the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;

2. 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 an **Insured** becomes **Permanently and Totally Disabled** as a result of a **Covered Injury**, We will pay a **Permanent and Total Disability Benefit** provided that he or she becomes **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 the **Insured's 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 the **Insured** is totally and continually disabled and cannot work, for any income, at any job that he or she is 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 remainder of the **Insured's** life.

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

## SECTION VI – ADDITIONAL BENEFITS

### DAY CARE BENEFIT

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her **Covered Spouse/Domestic Partner** suffers 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 **Principal Sum** of the **Covered Person** who suffered the **Covered Loss**; or
3. \$12,000.

If both the **Insured** and his or her **Covered Spouse/Domestic Partner** suffer a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on the **Insured's 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 the **Insured** selects a **Plan** covering his or her **Dependent Child(ren)** and the **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, We will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Covered Dependent Child**.

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

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



from the date of the **Accident**.

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

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

#### **SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT**

If an **Insured** selects a **Plan** covering his or her **Spouse/Domestic Partner**, and the **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay to his or her **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 the death of the **Insured**; and
3. the professional or trade training program is licensed by the state.

The maximum amount payable 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 the **Spouse/Domestic Partner** and/or **Child(ren)** are with the **Insured** while he or she is covered under this **Policy**. The **Spouse/Domestic Partner** or **Child(ren)** will not be covered while making a trip without the **Insured**. 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.

##### **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 supercedes or modifies the other **Coverages** provided under this **Policy**.

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

## SECTION VII – GENERAL EXCLUSIONS

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

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted Injury;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of any felony, an assault, insurrection or riot;
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** as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

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

## SECTION IX - TERMINATION OF INSURANCE

Within fifteen (15) days of **Policyholder's** receipt of termination, the **Policyholder** will notify **You** of such termination if **Your** premium is payroll deducted.

#### 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 zero (0) days in advance of such termination. We will calculate and return the unearned premium, if any, using a standard short rate table. The Policyholder will send Us any additional amounts owed, if any, between the Policy's paid to date and the official date of termination.

**Termination by Us.** We may terminate this **Policy** by giving the **Policyholder** at least 180 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 if the payment is not received prior to the end of the **Grace Period**. The **Policy** will remain in force until the last day of the **Grace Period**. We will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records. Within fifteen (15) days of **Policyholder's** receipt of termination, the **Policyholder** will notify **Insureds** of such termination to those **Insured's** whose premium is payroll deducted. **Coverage** will not be terminated by **Us** until notice has been properly provided to the **Policyholder**.

#### A. Termination of Individual's Insurance.

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

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

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

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

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

#### Conversion Privilege

If the insurance of an **Insured** ceases for reasons other than termination of the **Policy** or nonpayment of premium, the **Insured** is entitled to convert his or her **Coverage** to an **Individual Accidental Death or Dismemberment (IAD)** policy or to a **Family AD&D (FAD)** policy if the **Insured** selected a **Plan** covering his or her **Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. The **Insured** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of

insurance under the Group **Accident Policy**. To request a Conversion Application Form, the **Insured** must call 1-800-834- 1959. The **Insured** does not have to show proof of good health.

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

1. the **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of the **Insured's Principal Sum** under the Group **Accident Policy** or \$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 the **Insured's** insurance under the Group **Accident Policy**; and
4. when an **IAD** or **FAD** policy becomes effective, the relationship between the **Insured** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

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

## SECTION X - HOW TO FILE A CLAIM

- A. **Notice.** 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 You, and the Policy Number. To request a claim form, You or Your beneficiary, or someone on Your behalf may contact Us at . The notice must be sent to the Claims Department, Zurich American Insurance Company, , 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.**
- 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. **Validation of Policy.** The validity of the Policy will not be contested, except for nonpayment of premium, after it has been in force for two years from the effective date. No statement made by the Covered Person under the Policy relating to the Covered Person's insurability or the insurability of Your Dependents will be used in contesting the validity of the Policy with respect to which such statement was made: (1) after the Policy has been in force prior to the contest for period of two years during the lifetime of the Covered Person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by the Covered Person
- G. **Written Statements.** No written statement made by an Insured will be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

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.



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Kristof Terryn  
President  
Zurich American Insurance Company



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Laura J. Lazarczyk  
Corporate Secretary  
Zurich American Insurance Company

### NON-PARTICIPATING

#### IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event **You** need to contact someone about this insurance for any reason please contact the **Policyholder's** agent. If an agent was not involved in the sale of this insurance or if **You** have additional questions, **You** may contact Zurich American Insurance Company, . The telephone number is: .

In the event **You** are unable to contact or obtain satisfaction from the **Company** or agent, **You** can contact the Virginia State Corporation Commission's Bureau of Insurance at: Street Address: Tyler Building, 1300 E. Main St., Richmond, Virginia 23219 Mailing Address: P.O. Box 1157 Richmond, Virginia 23218 Phone: (Richmond area) 804-371-9691. National toll free number: 877-310-6560

**The Aerospace Corporation**  
**GTU8365008**  
**Effective: January 1, 2024**

Aug/2024

**Safety Device Benefit**

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ZURICH AMERICAN INSURANCE COMPANY

Schaumburg, Illinois

This endorsement, effective January 1, 2025, forms a part of **Policy** No. GTU8365008, issued to The Aerospace Corporation.

**THIS ENDORSEMENT CHANGES THE POLICY. 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 **Policy**:

**SECTION II – SCHEDULE** is amended to include the following:

**ADDITIONAL BENEFITS:**

Safety Device Benefit

**Classes Covered**

Class I

**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 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 **Insured** is actively at work.
- j. **Approved Body Armor** while the **Insured** is actively at work.

Verification of the **Covered Person** 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 alcohol:
  - a. a driver/operator will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle.
  - b. an autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the; or
- 2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage; or
- 3. 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).

**Approved Body Armor** means a ballistic-resistant vest complying with National Institute of Justice (NIJ) Standard-0101.06 or subsequent standard(s).

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

Endorsement No. as issued with policy



**NOTICE OF  
PROTECTION PROVIDED BY  
VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,000 in cash surrender or withdrawal values
  
- Health Insurance
  - \$500,000 for health benefit plans
  - \$300,000 in disability income insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of accident and sickness insurance benefits
  
- Annuities
  - \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for health benefit plans, for which the limit is increased to \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association’s website at [www.valifega.org](http://www.valifega.org) or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION  
c/o APM Management Services, Inc.  
1503 Santa Rosa Road, Suite 101  
Henrico, VA 23229-5105  
804-282-2240

STATE CORPORATION COMMISSION  
Bureau of Insurance  
P. O. Box 1157  
Richmond, VA 23218-1157  
804-371-9741  
Toll Free Virginia only: 1-800-552-7945  
<http://www.scc.virginia.gov/boi/index.aspx>

**Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to 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 Virginia law, then Virginia law will control.**

# SANCTIONS EXCLUSION ENDORSEMENT



## **THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY**

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

### **SANCTIONS EXCLUSION**

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

### **ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED**





## 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.

<b>Overview</b>	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
<b>Why are you receiving this Notice?</b>	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.
<b>What types of Information do we collect?</b>	<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"><li>• 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;</li><li>• Information about your transactions with the Company and its affiliates;</li><li>• Information about your insurance coverage, premiums, claims history, and payment history;</li><li>• Data from insurance support organizations, government agencies, insurance information sharing bureaus;</li><li>• Property information and similar data about you or your property, such as property appraisal reports; and</li><li>• Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report.</li></ul> <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>

<b>What do we do with the NPI we collect?</b>	<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"> <li>• Financial service providers, such as banks and other insurance companies;</li> <li>• Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and</li> <li>• Others, such as consumer reporting agencies and insurance information sharing bureaus.</li> </ul> <p>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).</p>
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<b>Reasons we can share your personal information</b>	<b>Does Company Share?</b>	<b>Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?</b>
<b>For our everyday business purposes</b> – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
<b>For our marketing purposes</b> - to offer our products and services to you	Yes	No
<b>For joint marketing with other financial companies</b>	No	Not Applicable
<b>For our affiliates' everyday business purposes</b> – transaction and experience information	Yes	No
<b>For our affiliates' everyday business purposes</b> – information about your creditworthiness	No	Not Applicable
<b>For our affiliates to market to you</b>	Yes	No
<b>For non-affiliates to market their products to you</b>	No	Not Applicable

<b>Collecting and safeguarding information</b>	
<b>How often do you notify me about your privacy practices?</b>	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.
<b>Why do you collect my NPI?</b>	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.
<b>What NPI do we share?</b>	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?"



<b>How do you safeguard my NPI?</b>	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.
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**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 tollfree 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](mailto: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.

<b>Key words and phrases</b>	<b>TERMS YOU SHOULD KNOW</b>
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<b>Definitions</b>	
<b>Everyday business purposes</b>	<p>The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as:</p> <ul style="list-style-type: none"> <li>• Processing transactions, mailing and auditing services;</li> <li>• Administering insurance coverage, product, services or claims;</li> <li>• Providing information to credit bureaus;</li> <li>• Protecting against fraud;</li> <li>• Responding to court/governmental orders or subpoenas and legal investigations; and</li> </ul>

	<ul style="list-style-type: none"> <li>• Responding to insurance regulatory authorities.</li> </ul>
<b>Affiliates</b>	<p>Financial or nonfinancial companies related by common ownership or control.</p> <ul style="list-style-type: none"> <li>• <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></li> </ul>
<b>Nonaffiliated Third Parties</b>	<p>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.</p> <ul style="list-style-type: none"> <li>• <i>The Company does not share information with nonaffiliates to market their products to you.</i></li> </ul>

<b>Joint marketing</b>	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>• <i>The Company does not jointly market.</i></li> </ul>
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<b>Changes to this Privacy Notice; contact us</b>	<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 <a href="mailto:privacy.office@zurichna.com">privacy.office@zurichna.com</a>.</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.*