Certificate of Insurance

ZURICH

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 5091217 to cover the eligible individuals of:

San Bernardino City Unified School District

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

TABLE OF CONTENTS

SECTION I – ELIGIBILITY AND EFFECTIVE DATES

CERTIFICATEHOLDER:

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

Class II: All **Active** full-time and part-time Employees domiciled in the United States electing additional amounts of coverage.

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

YOUR EFFECTIVE DATE OF INSURANCE:

A. For eligible individuals hired prior to July 1, 2019:
July 1, 2019, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For eligible individuals hired on or after July 1, 2019:
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, Excluding Corporate Owned or Leased Aircraft,	All
Exposure and Disappearance Coverage	All

BENEFITS:	**Classes Covered**
ACCIDENTAL DEATH BENEFIT	All

Principal Sum:

Class I: $1,000

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

* **Base Annual Earnings** means **Your** base annual pay excluding overtime, bonuses, commissions and special compensation.

The **Principal Sum** for **Covered Dependents** will be a percentage of **Your Principal Sum**, as follows:

Plan Selected	**% Spouse**	**% Child(ren)**
Spouse only:	60%	0
Dependent Child(ren) only:	0	20%
Spouse and **Dependent Child(ren)**	50%	10%

Maximum of $25,000 **Principal Sum** for **Dependent Child(ren)**.

	Classes Covered
ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT **Principal Sum**: Same as above.	All
Coma Benefit	All

ADDITIONAL BENEFITS:	**Classes Covered**
Common Disaster Benefit	All
Day Care Benefit	All
Felonious Assault Benefit	All
Higher Education Benefit	All
Seat Belt/Air Bag Benefit	All
Spouse Retraining Benefit	All
Travel Assistance Plan	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** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse** and/or **Dependent Child(ren)**.

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

Dependent Child(ren), if used in the **Policy,** means **Your** unmarried **Child(ren)** 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.

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

Spouse, if used in 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 EXCLUDING 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 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. 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;**

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

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

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

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

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the **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.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

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

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

ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT

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

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

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

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

For purposes of this benefit:

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

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

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.

SECTION VI – ADDITIONAL BENEFITS

COMMON DISASTER BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** 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 Accidental Death** will be increased to equal that payable for **Your** loss, provided:

1. **You** and **Your Covered Spouse** are survived by one or more **Covered Dependent Child(ren)**; and
2. the combined benefits of **You** and **Your Covered Spouse** are not more than $800,000.

DAY CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse** 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. 3% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. $3,600.

If both **You** and **Your Covered Spouse** 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.

The maximum amount payable under this benefit is $14,400.

FELONIOUS ASSAULT BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit** or **Accidental Dismemberment and Plegia Benefit** as a result of a violent or criminal act committed by someone other than **You**, a **Fellow Employee** or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to 10% of **Your Principal Sum**, provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises; and
2. the crime directly involves the **Policyholder's** funds or assets.

For purposes of this benefit:

Fellow Employee means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the defined violent crime/felonious assault was committed.

Family means **Your** parent, step-parent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

Household means a person who maintains residence at the same address as **You**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

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 $5,000. 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 $2,000 to the designated beneficiary.

SEAT BELT/AIR BAG BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay to the beneficiary an additional benefit, which equals 10% of the applicable **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 designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

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

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

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

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

1. under the influence of alcohol;
   a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.

b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,

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

SPOUSE RETRAINING BENEFIT

If **You** selected a **Plan** covering **Your Spouse** 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** the actual cost of any professional or trade-training program in which the **Covered Spouse** 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 $3,000.

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** 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. participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous-activity;
7. being intoxicated.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
8. being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
9. travel or flight in any aircraft except to the extent stated in the **Coverage** Section;

10. release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
11. a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident;**
12. alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider within his or her scope of authority.

SECTION VIII – GENERAL LIMITATIONS

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

Limitation on Multiple Benefits. If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit**, **Accidental Dismemberment and Plegia Benefit, Coma 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.

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**; or
3. for the **Covered Spouse**, the date the **Covered Spouse** reaches 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**;
    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

San Bernardino City Unified School District
GTU 5091217
Effective: October 5, 2022

Version: October 2022

Revised Definition of Spouse 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 San Bernardino Unified School District Policy/Certificate.

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

PURPOSE: California law provides that registered domestic partners have the same rights, protections, and benefits, and are subject to the same responsibilities, obligations, and duties under law, whether they derive from statutes, administrative regulations, court rules, government policies, common law, or any other provisions or sources of law, as are granted to and imposed upon spouses. Existing law requires, where necessary to implement the rights of registered domestic partners, gender-specific terms referring to spouses to be construed to include domestic partners.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:
The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

"Spouse" includes a Registered Domestic Partner.

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: October 5, 2022 Attached to and forming a part of Policy/Certificate No. GTU 5091217

Signed for Zurich American Insurance Company by: _____ Date: October 5, 2022

AMENDATORY ENDORSEMENT

Premium Refund on a Pro Rata Basis

ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

This endorsement, effective July 1, 2019, forms a part of **Policy/Certificate** No. GTU 5091217, issued to San Bernardino City Unified School District.

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: October 5, 2022

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. March 2019***

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?	The types of NPI we collect depend on the product or service you have with us. This information can include: • 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, such as a credit report. When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.

What do we do with the NPI we collect?	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. These affiliates and nonaffiliated third parties include: • 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 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	No
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	No
For our affiliates to market to you	Yes	No
For non-affiliates to market their products to you	No	No

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.
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 written request reasonably describing the information you seek, and send your written request to: 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 you request medical records, we may elect to supply that information to you through your designated medical professional. 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 in writing, 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 must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@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: • 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. • *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.*
Nonaffiliated Third Parties	Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your NPI. However, 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. • *Company does not share information with nonaffiliates to market their products to you*.

Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • *Company does not jointly market.*
Changes to this Privacy Notice; contact us	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. If you have any questions about your contract with us, you should contact your agent. 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.

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.