



**GROUP VOLUNTARY
ACCIDENT POLICY**

FOR

ONEBEACON INSURANCE COMPANY

**THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.
IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR
LOSSES DUE TO SICKNESS.**

This Policy is a Legal Contract between the Policyholder and the Insurer.

Please read this Policy carefully.

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: OneBeacon Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICY NUMBER: 212-000-009

ORIGINAL POLICY EFF. DATE: January 1, 2008

REWRITE POLICY EFF. DATE: January 1, 2011
(This Policy is a rewrite of the Policy issued January 1, 2008 under the same policy number.)

POLICY EXPIRATION DATE: Continuous

POLICY ANNIVERSARY DATE: January 1st

COVERED SUBSIDIARIES OR AFFILIATED COMPANIES:
A.W.G. Dewar, Inc.
Guilford Holdings, Inc.
OneBeacon Professional Insurance, Inc.
White Mountains Capital, Inc.
White Mountains Inc.
White Mountains Insurance Group, Ltd.

This Policy is a legal contract between the Policyholder and the Insurer. The Insurer agrees to insure eligible persons of the Policyholder, for whom premium is paid, against loss covered by this Policy, subject to its provisions, limitations and exclusions.

This Policy takes effect on the Policy Effective Date. All periods of insurance begin and end when 12:01 AM, Standard Time occurs at the Policyholder's address. This Policy remains in force for the period for which premium has been paid.

This Policy is governed by the laws of the state in which it is delivered.

In Witness Whereof, We have caused this Policy to be executed and attested, and, if required by state law, this Policy shall not be valid unless countersigned by our authorized representative.



Dennis R. Smith, Secretary
OneBeacon America Insurance Company



Michael Miller, President & CEO
OneBeacon America Insurance Company

Countersigned _____
Authorized Representative Date

GROUP ACCIDENTAL DEATH & DISMEMBERMENT POLICY

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SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

PRIMARY INSURED PERSON.

Eligibility. The following individuals are eligible to become **Primary Insured Persons** upon the submission of completed enrollment materials, if required:

<u>Class</u>	<u>Description</u>
1	All Active employees of the Policyholder working a minimum of 20 hours per week.

- Effective Date.**
- A. For eligible individuals hired prior to January 1, 2008:
January 1, 2008, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.
 - B. For eligible individuals hired on or after January 1, 2008:
their first day of **Active** work provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

If the eligible individual is not **Actively at Work** on his or her Effective Date of coverage, coverage will begin on his or her first full day of **Active** work following his or her Effective Date.

Termination Date. Coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

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

If a **Primary Insured Person** 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.

PRIMARY INSURED PERSON'S DEPENDENTS.

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

Effective Date. **Dependent** coverage begins on the later of:

1. the date the **Primary Insured Person's** coverage begins, provided the **Primary Insured Person** has requested **Dependent Coverage** on his or her enrollment materials;
2. the date the **Primary Insured Person** requests to add coverage for his or her eligible **Dependents** in the applicable benefit materials; or
3. the date he or she becomes an eligible **Dependent**.

Termination Date. Coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. the **Dependent** ceases to be eligible for insurance;
3. the coverage of the **Primary Insured Person** terminates, except in such situations where the written policy of the **Policyholder** allows such **Primary Insured Person** to continue coverage for his or her **Covered Dependents**;
4. the **Primary Insured Person** fails to pay the required premium, if so required;
5. for the **Covered Spouse/Domestic Partner** only, the **Covered Spouse/Domestic Partner** reaches age 70.

If a **Primary Insured Person** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, insurance for his or her **Covered Dependents** under this **Policy** may 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.

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

Class 1 including their **Covered Dependents**, if any: 24 Hour **Accident** Protection, Business and Pleasure, Including Corporate Owned or Leased Aircraft, and **Substitute Aircraft**, Passenger and Crew

Additional Coverages

Class 1: Specified Pilot Coverage

Class 1 and their **Covered Dependents**, if any: Exposure and Disappearance Coverage

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

Class 1 An employee may purchase an amount of **Principal Sum** from a minimum of one (1) times their **Base Annual Earnings*** to a maximum six (6) times their **Base Annual Earnings***, rounded up to the next highest \$1,000, to a maximum amount of \$500,000.

***Base Annual Earnings** means the employee's base annual pay excluding overtime, bonuses, commissions and special compensation.

The following are the **Principal Sums** for **Covered Dependents**:

The **Principal Sum** for **Covered Dependents** will be a percentage of the employee's **Principal Sum**:

<u>Plan Selected</u>	<u>% Spouse/Domestic Partner</u>	<u>% Child(ren)</u>
Spouse/Domestic Partner only:	60%	0
Dependent Child(ren) only:	0	20%
Spouse/Domestic Partner and Dependent Child(ren)	50%	15%

Maximum of \$25,000 **Accidental Death Benefit** for **Dependent Child(ren)**.

Principal Sum Reduction

At age 70, for the **Primary Insured Person** only, the **Principal Sum** will be reduced based on the **Primary Insured Person's** previous **Principal Sum** per the following schedule:

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

B. Accidental Death Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

C. Accidental Dismemberment and Covered Loss of Use Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

D. Coma Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

E. Additional Benefits

Class 1:

Additional Dismemberment Benefit for Children
Continuation of Coverage Benefit
Rehabilitation Benefit
Spouse Vocational Training Benefit

Class 1 and their **Covered Dependents**, if any:

Day Care Benefit
Higher Education Benefit
Seat Belt Benefit
Travel Assistance

SECTION III – PREMIUM

Premium Due Date: 15th day of month following month of coverage

Premium Amount:

Employee Only:	\$0.022 per \$1,000 of Principal Sum per month
Employee & Dependents:	\$0.040 per \$1,000 of Principal Sum per month

Grace Period. Premiums are due for this **Policy** on or before the premium due date. If the **Policyholder** does not pay a premium when it is due, there is a thirty-one (31) day **Grace Period** to pay. During the **Grace Period**, the **Policy** will stay in force. The **Policyholder** will be liable for payment of the premium for the time this **Policy** remains in force during the **Grace Period**, unless proof is provided to **Us** that this **Coverage** has been replaced during such period. The **Policyholder** will not have a **Grace Period** if **We** have given written notice, at least thirty (30) days in advance, that **We** are going to terminate this **Policy**, or if **We** receive written notice, at least thirty (30) days in advance, to terminate this **Policy** prior to a premium due date.

SECTION IV – HAZARDS

24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE INCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, AND SUBSTITUTE AIRCRAFT, PASSENGER AND CREW

This **Policy** insures against the following **Hazards**:

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

Hazard Limitations:

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

1. 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:
 - a. medical certificate; and
 - b. pilot certificate with a proper rating to pilot such aircraft.
2. 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:

1. If the **Insured Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft except those aircraft specified below.
2. 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:
 - a. any aircraft other than those expressly stated in this **Hazard**;
 - b. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**; except the following aircraft, including **Substitute Aircraft**:

B300 Raytheon King Air FAA Certificate Number N603WM
B350 Raytheon King Air FAA Certificate Number N450DW

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 1,000 hours as a pilot of which at least 500 hours were logged in this or the same class of aircraft.

- c. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** or a member of an **Insured Person's** family or household;
- d. any aircraft operated by the **Policyholder** except those indicated in b. above, including **Substitute Aircraft** or one of the **Policyholder's** employees including members of an employee's family or household;
- e. any aircraft engaged in a **Specialized Aviation Activity**;
- f. any conveyance used for tests or experimental purposes, or in a race or speed test.

Hazard Definitions:

- **Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
 1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
 2. is the same class of aircraft as the specified aircraft; and

3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.

Note: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.

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

SECTION V – ADDITIONAL COVERAGES

EXPOSURE AND DISAPPEARANCE COVERAGE

If an **Insured 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 an **Insured Person** is riding disappears, is wrecked, or sinks, and the **Insured 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 **Insured Person** survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

SPECIFIED PILOT COVERAGE

The **Hazard** Exclusion in **24 Hour Accident Protection, Business and Pleasure Including Corporate Owned or Leased Aircraft, and Substitute Aircraft, Passenger and Crew** stating that “**Coverage** is not provided: 1. if the **Insured Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft.” is modified to provide **Coverage** for the following named pilot(s) only:

any employee of the **Policyholder** who is covered under this **Policy** and who is a qualified pilot while piloting the following aircraft:

his or her private plane while on the **Business of the Policyholder** as defined below provided such aircraft has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor, and the above named pilot(s) has a current and valid medical certificate and pilot certificate with a proper rating to fly such aircraft.

Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation. It does include **Personal Deviations/Side Trips** of a personal nature.
- **Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; 3) is taken during the course of the business trip; and 4) is limited to 72 hours.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

SECTION VI – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if an **Insured Person** sustains a loss of life as a result of a **Covered Injury**, and the death occurs within 365 days of the **Covered Injury**.

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

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

We will pay the benefit amount shown below, if an **Injury** to an **Insured Person** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within 365 days of the **Accident**.

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

<u>Covered Loss of</u>	<u>Benefit</u>
• Both Hands or Both Feet	Principal Sum
• One Hand and One Foot	Principal Sum
• One Hand or One Foot plus the loss of Sight of One Eye	Principal Sum
• Sight of Both Eyes	Principal Sum
• Speech and Hearing	Principal Sum
• Speech or Hearing	50% of Principal Sum
• One Hand; One Foot; or Sight of One Eye	50% of Principal Sum
• Thumb and Index Finger of the same Hand	25% of Principal Sum

<u>Covered Loss of Use of</u>	<u>Benefit</u>
• Both Arms and Both Legs	Principal Sum
• Both Arms or Both Legs or a Combination of an Arm and a Leg	75% of Principal Sum
• One Arm or One Leg	50% of Principal Sum
• Both Hands or Both Feet or a Combination of a Hand and a Foot	50% of Principal Sum
• One Hand or One Foot	25% of Principal Sum

A reduced benefit will be payable equal to 50% of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after 365 days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.

For purposes of this benefit:

- **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.
- **Covered Loss of Use** means total paralysis of an arm, leg, hand, or foot, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible.

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

COMA BENEFIT

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

The **Coma Benefit** is equal to 1% of the **Insured Person's Principal Sum**, and will be paid each month the **Insured 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 **Insured Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. the **Insured Person** has received a **Coma Benefit** for 100 months.

Brief periods of consciousness of no more than one (1) day in duration will not affect the **Insured Person's** eligibility for, or continuation of, benefits.

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

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

SECTION VII – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

We will pay the **Primary Insured Person** a benefit that will be equal to an additional 100% of the benefit amount provided by the **Accidental Dismemberment Benefit** that is payable under the **Accidental Dismemberment Benefit**, if the **Primary Insured Person** selects a **Plan** covering his or her eligible **Dependent Child(ren)**, and a **Covered Dependent Child** sustains an **Injury** resulting in a **Covered Loss**.

CONTINUATION OF COVERAGE BENEFIT

All **Coverages** under this **Policy** that were in force on the date of the indicated **Covered Loss**, with respect to **Insured Persons** other than the **Primary Insured Person**, will be continued automatically for 365 days after the date of the **Covered Loss** at no additional cost, if the **Primary Insured Person** selects a **Plan** covering his or her **Dependents**, and the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**.

DAY CARE BENEFIT

We will pay an additional benefit for Day Care expenses, if a **Primary Insured Person** selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person** or his or her **Covered Spouse/Domestic Partner** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid 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 **Covered 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 Day Care;
2. 3% of the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss**; or
3. \$3,000.

If both the **Primary Insured Person** and his or her **Covered Spouse/Domestic Partner** sustains a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on the **Primary Insured Person's Principal Sum**.

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

1. the **Covered Dependent Child** is under age thirteen (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

We will pay an additional benefit for Higher Education expenses, if a **Primary Insured Person** selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person** or his or her **Covered Spouse/Domestic Partner** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid 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 as a full-time student in an accredited college, university or trade school; or
2. the **Covered Dependent Child** 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 Benefit** will be equal to the lesser of:

1. 5% of the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss**; or
2. \$5,000.

If both the **Primary Insured Person** and his or her **Covered Spouse/Domestic Partner** sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Higher Education Benefit** will be based on the **Primary Insured Person's Principal Sum**.

The **Higher Education Benefit** will be paid annually for up to four (4) consecutive years, if:

1. the **Covered Dependent Child** continues his or her Higher Education ; and
2. proof, acceptable to Us, is received by Us that verifies that the **Covered Dependent Child** remains enrolled in an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering the **Primary Insured Person'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.

REHABILITATION BENEFIT

We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, if the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**. The benefit will be in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. \$10,000; or
3. 10% of the **Primary Insured Person's Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed **Physician** acting within the scope of his or her license that is approved by Us prior to the provision of services;
2. is required due to the **Primary Insured Person's Injury**; and
3. prepares the **Primary Insured Person** for an occupation that he or she would not have engaged in except for the **Injury**.

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

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

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

SEAT BELT BENEFIT

We will pay an additional benefit equal to 10% of the applicable **Principal Sum** up to a maximum of \$25,000, if an **Insured Person** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that the **Insured 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 **Insured 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.

We will not pay a **Seat Belt Benefit** if the **Insured Person** is the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and is either:

1. under the influence of alcohol;
 - a. An **Insured 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 **Insured Person's** intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.

SPOUSE/DOMESTIC PARTNER VOCATIONAL TRAINING BENEFIT

We will pay the actual cost of any professional or trade-training program in which the **Primary Insured Person's Covered Spouse/Domestic Partner** enrolls, if the **Primary Insured Person** selects a **Plan** covering his or her **Spouse/Domestic Partner**, and the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to his or her **Covered Spouse/Domestic Partner**, 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 **Primary Insured Person**; and
3. the professional or trade training program is licensed by the state.

The maximum amount payable under this benefit will be the lesser of 2% of the **Primary Insured Person's Principal Sum** or \$3,000.

TRAVEL ASSISTANCE

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

• **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

If an **Insured 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 **Insured 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.

Assisted Repatriation

If an **Insured 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 **Insured 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.

Post-Recovery Repatriation

If an **Insured 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 an **Insured 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 an **Insured 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 **Insured Person** to visit the **Insured Person** while he or she is hospitalized. **We** must pre-authorize the transportation for benefits to be payable.

Return of Child

If an **Insured 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 **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured 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 **Insured 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 an **Insured Person** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured 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 **Travel Assistance** if the **Coverage** is excluded under Section IX 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 deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;

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 **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED 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 **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured 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.

Principal Residence means the legal domicile of the **Insured Person**.

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

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

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **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 **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.

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 **Travel Assistance**, is solely covered under **Travel Assistance**, and in no way supercedes or modifies the other **Coverages** provided under this **Policy**. All other **Coverages** provided under this **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call 1-866-670-6693 from the U.S. or Canada; and collect from anywhere else in the world at +1-973-630-6693.

SECTION VIII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if an **Insured Person** sustains more than one loss as a result of the same **Accident**.

Limitation on Multiple Benefits.

The most We will pay for the following benefits, in total, is the **Insured Person's Principal Sum**, if the **Insured Person** can recover benefits under more than one of these: **Accidental Death Benefit, Accidental Dismemberment and Covered Loss of Use Benefit and Coma Benefit**, as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit, if an **Insured Person** sustains a **Covered Loss** that is covered under more than one **Hazard**.

SECTION IX – GENERAL EXCLUSIONS

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

- suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
- war or any act of war, whether declared or undeclared;
- involvement in any type of active military service. (For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service.);
- illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in any aircraft except to the extent stated in the **Hazards** Section.

SECTION X – TERMINATION OF POLICY

Termination by the 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 (unless **We** agree to an earlier date).

Upon receipt of such written notice, **We** will calculate and return the unearned premium, if any, using a pro-rata 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 thirty (30) days written notice of **Our** intent to terminate (unless the **Policyholder** agrees to an earlier date). Such written notice will state the exact date the **Policy** will terminate.

We may also end this **Policy** for nonpayment 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 written notice of such termination to the **Policyholder's** last address shown in **Our** records.

If **We** or the **Policyholder** terminate this **Policy**, **Coverage** will end when it is 12:01 AM, Standard Time, on the day following the last day of **Coverage**, at the **Policyholder's** address.

If this **Policy** is terminated, the termination will not affect a claim incurred prior to the termination date of the **Policy**.

SECTION XI – CLAIMS PROVISIONS

Notice. The **Primary Insured Person** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name the **Insured Person** who sustained the **Injury**, the **Primary Insured Person**, and the **Policy** Number. To request a claim form, the **Primary Insured Person** or the beneficiary, or someone on their behalf may contact **Us** at 866-583-2233. The notice must be sent to the Claims Department, OneBeacon America Insurance Company, P.O. Box 1009, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

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 the extent of the **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**.

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.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **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**.

Recipient of Payment.

1. Loss of Life of a **Primary Insured Person**. **Covered Losses** resulting from the **Primary Insured Person's** 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 the **Primary Insured Person**, **We** will pay the benefit to the **Primary Insured Person's** survivors in the following order:
 - a. the **Primary Insured Person's Spouse/Domestic Partner**;
 - b. the **Primary Insured Person's** child(ren);
 - c. the **Primary Insured Person's** parents;
 - d. the **Primary Insured Person's** brothers and sisters;
 - e. the **Primary Insured Person's** estate.
2. Loss of Life of a **Covered Dependent**. **Covered Losses** for the death of a **Covered Dependent** will be paid to the **Primary Insured Person**. If the **Primary Insured Person** pre-deceases or dies at the same time as the **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 the **Primary Insured Person's** estate.
3. All Other Claims. Benefits are to be paid to the **Primary Insured Person**.

Physical Examination and Autopsy. We have the right to examine an **Insured 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.

Choice of Service Provider. The **Insured Person** has the sole right to choose his or her duly licensed **Physician** and hospital.

Right to Recover Overpayments. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, **We** will have the right to recover such excess

payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under this **Policy** to the extent of the overpayment.

Suit Against Us. No action on this **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 **Insured 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.

ERISA Claims Fiduciary. The **Policyholder** agrees that the **Policy** constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The **Policyholder** designates **Us** or a person or persons which **We** designate as the claims fiduciary of this plan and gives **Us** the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The **Policyholder** agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and **Our** designation and authority as the claims fiduciary.

SECTION XII – GENERAL PROVISIONS

Beneficiaries. The **Primary Insured Person** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Primary Insured Person** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this **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**.

Change or Waiver. A change or waiver of any terms or conditions of this **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 this **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue a **Primary Insured Person's Coverage**, which otherwise would not be in force. If a **Primary Insured Person** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Entire Contract. This **Policy**, together with any riders, endorsements, amendments, applications, completed enrollment materials, and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

Primary Insured Person Certificates. **We** will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Primary Insured Persons**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Primary Insured Persons**. Such **Certificate** will contain a summary of terms that affect benefits.

Policyholder Records/Audit. The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Primary Insured Person**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. **We** reserve the right to charge or refund premium, as applicable. The **Policyholder** will report to **Us**, within a reasonable time, all changes in information regarding a **Primary Insured Person**. The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function. In addition, the **Policyholder** will be liable for any retroactive premium.

Renewal. This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.

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.

Incontestability. The validity of this **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

Newly Acquired Aircraft. If the **Policyholder** acquires ownership or possession under a lease agreement of additional aircraft, and the **Policyholder** notifies **Us** of such acquisition or possession within sixty (60) days after the delivery of the **Newly Acquired Aircraft**, the aircraft **Coverage** provided in Section IV **Hazards**, will also apply to the **Newly Acquired Aircraft** upon delivery of such aircraft to the **Policyholder**.

If the **Policyholder** does not notify **Us** of a **Newly Acquired Aircraft** within sixty (60) days after its delivery, or does not pay the additional premium required, if any, **Coverage** for the **Newly Acquired Aircraft** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

Newly Acquired Corporation. If the **Policyholder** acquires a corporation through stock purchase, exchange of stock or otherwise, and notifies **Us** of such acquisition within ninety (90) days thereafter, the eligible employees of the **Newly Acquired Corporation** will be insured under this **Policy** as of the effective date of such acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, within the ninety (90) days, or does not pay such additional premium, if

any, as required, the **Coverage** for the employees of the **Newly Acquired Corporation** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

SECTION XIII – 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** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her 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 the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **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 **Hazards** 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** Section and Additional Coverages Section of this **Policy** to which benefits and additional benefits apply. The **Hazards** and Additional Coverages are listed in the Schedule.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under this **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 this **Policy**.
- **Dependent** means a **Primary Insured Person's Spouse/Domestic Partner** and **Dependent Child(ren)**, as defined in this Section. The **Dependent** will only be a **Covered Dependent** if the **Primary Insured Person** selects a **Plan** covering his or her **Dependents**.
- **Dependent Child(ren)**, if used in this **Policy**, means those unmarried **Child(ren)** of the **Primary Insured Person**, and those unmarried **Child(ren)** of his or her **Spouse/Domestic Partner** who rely on the **Primary Insured Person** for more than 50% of their support, and are less than 26 (twenty-six) years of age or 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 the **Primary Insured Person** selects a **Plan** covering his or her **Dependent Child(ren)**.
- **Domestic Partner**, if used in this **Policy**, means a person, under age 70, who qualifies as a **Domestic Partner** under this **Policy**. A **Domestic Partner** will only be a **Covered Domestic Partner** if the **Primary Insured Person** selects a **Plan** covering his or her eligible **Domestic Partner**. To qualify as a **Domestic Partner** under this **Policy**, the following requirements must be met:
 1. the **Primary Insured Person** and the **Domestic Partner** must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;
 2. the **Primary Insured Person** and the **Domestic Partner** must have lived together in such a relationship for a period of not less than twelve (12) consecutive months at the same residence address;
 3. the **Primary Insured Person** and the **Domestic Partner** must both be at least 18 years of age;
 4. neither the **Primary Insured Person** nor the **Domestic Partner** are legally married;
 5. the **Primary Insured Person** and the **Domestic Partner** are not related by blood or adoption;
 6. the **Primary Insured Person** and the **Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely; and
 7. the **Primary Insured Person** and the **Domestic Partner** must be of the same sex.

- **Injured, Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of this **Policy**. It includes the **Primary Insured Person**, and his or her **Spouse/Domestic Partner** and/or **Dependent Child(ren)** if the **Primary Insured Person** selects a **Plan** covering his or her **Spouse/Domestic Partner** and/or **Dependent Child(ren)**.
- **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**.
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule.
- **Policy** means this Group **Accident Insurance Policy**.
- **Policyholder** means the group named on the front page of this **Policy**.
- **Primary Insured Person** means an individual who is eligible for coverage under this **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I; and who completes the enrollment material.
- **Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

acrobatic or stunt flying	hanggliding
aerial photography	hunting
banner towing	parachuting or skydiving
bird or fowl herding	pipe line inspection
crop dusting	power line inspection
crop seeding	racing
crop spraying	skywriting
endurance tests	test or experimental purpose
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	
- **Spouse**, if used in this **Policy**, means the **Primary Insured Person's** legally married **Spouse** under age 70. A **Spouse** will only be a **Covered Spouse** if the **Primary Insured Person** selects a **Plan** covering his or her eligible **Spouse**.
- **Under lease**, as used in the **Hazards** 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 OneBeacon America Insurance Company.

Policyholder: OneBeacon Insurance Company
Policy Number: 212-000-009
Original Policy Effective Date: January 1, 2008
Rewrite Policy Effective Date: January 1, 2011

Underwritten by: OneBeacon America Insurance Company



Policyholder: OneBeacon Insurance Company
Policy Number: 212-000-009

Effective Date of Endorsement: January 1, 2011

ADMINISTRATIVE CHANGE ENDORSEMENT

It is hereby understood and agreed that as of the effective date indicated above, the following change is made to this **Policy**:

The provision found under **Termination Date** in “**SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE**” as it appears on page 4 of this **Policy** is deleted in its entirety and replaced with the following:

If a **Primary Insured Person** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, or is on a list of grandfathered employees on LTD as on file with **Us** and the **Policyholder**, 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.

Additionally, the provision found under **Termination Date** in “**SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE**” as it appears on page 5 of this **Policy** is deleted in its entirety and replaced with the following:

If a **Primary Insured Person** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, or is on a list of grandfathered employees on LTD as on file with **Us** and the **Policyholder**, insurance for his or her **Covered Dependents** under this **Policy** may 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.

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. 1

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: OneBeacon Insurance Company
(amended below to OneBeacon Services, LLC)
Policy Number: 212-000-009

Effective Date of Endorsement: January 1, 2012

ADMINISTRATIVE CHANGE ENDORSEMENT

It is hereby understood and agreed that as of the effective date indicated above, the following change is made to this **Policy**:

I. The **POLICYHOLDER** name and address as it appears on page 2 of this **Policy** is amended as follows:

**OneBeacon Services, LLC
150 Royall Street
Canton, MA 02021**

II. The following is deleted from the list of “**COVERED SUBSIDIARIES OR AFFILIATED COMPANIES**” as it appears on page 2 of this **Policy**:

White Mountains, Inc.

III. The following is added to the list of “**COVERED SUBSIDIARIES OR AFFILIATED COMPANIES**” as it appears on page 2 of this **Policy**:

OneBeacon Insurance Company

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. 2

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company