NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: Saltchuk Resources, Inc.
Policy Number: GTP 0009133349-A

GROUP ACCIDENT INSURANCE CERTIFICATE

ABOUT THIS CERTIFICATE. This certificate describes accident insurance the Company provides to Insured Persons under the Group Policy (herein referred to the Policy) issued to the Policyholder. This insurance is provided to Insured Persons of the Policyholder while those persons are participating in Covered Hazards.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this certificate:

President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

Non-Participating

BENEFITS PROVIDED UNDER THE POLICY DO NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. THE POLICY DOES NOT COVER THE COST OF MOST HOSPITAL AND OTHER SUCH MEDICAL SERVICES. IT IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THE POLICY IS A LIMITED POLICY AND IS AN ACCIDENT ONLY POLICY.

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DECLARATIONS OF COVERAGE

ELIGIBILITY FOR COVERAGE – The persons eligible for coverage are:

Class I	All full-time employees, non-union of the Policyholder.

AMOUNT OF COVERAGE FOR EACH CLASS OF INSURED PERSON

Class	Principal Sum
I	Three (3) times Annual Base Salary with a minimum of $36,000 to a maximum of $350,000.

Benefits shown in any row of the Table shown below apply only to an eligible person in a Class shown in that row, only with respect to an accident that occurs under the circumstances described in a Hazard shown in that row as to such person. Any other Rider shown in any row of the Table shown below applies only with respect to the Classes, Hazards, Benefits, and Riders shown in that row.

TABLE OF HAZARDS, BENEFITS, AND RIDERS

Class	Hazards	Benefits	Riders
I	H-12	B-1, B-2, B-4, B-6, B-7, B-13, B-16, B-25, B-26, B-28	

DEFINITIONS

Airworthiness Certificate means the “Standard” Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

Civilian Aircraft means a civil or public aircraft having a current and valid Airworthiness Certificate and piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the aircraft. A Civilian Aircraft does not include a Policyholder Aircraft.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: spouse, Domestic Partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted child or stepchild).

Injury means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that that is external to the body and occurs while the injured person's coverage under the Policy is in force; (2) which occurs under the circumstances described in a Hazard applicable to that person; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss under a Benefit applicable to such Hazard.

Insured means a person: (1) who is a member of an Eligible Class of persons as described in the Eligibility for Coverage section; (2) for whom premium has been paid; and (3) while covered under the Policy.

Insured Person means an Insured.

Military Air Transport Aircraft means an aircraft having a current and valid Airworthiness Certificate; piloted by a person who has a current and valid medical certificate and pilot certificate with appropriate ratings for the aircraft; and operated by the United States of America, or by the similar air transport service of any duly constituted governmental authority of any other recognized country.

Passenger means a person not performing as a pilot, operator, or crew member of a conveyance.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: (1) the Insured Person; (2) an Immediate Family Member; or (3) retained by the Policyholder.

Policyholder Aircraft means any aircraft with a current and valid Airworthiness Certificate and owned, leased or operated by the Policyholder.

Sojourn and Personal Deviation, Sojourn or Personal Deviation means non-business travel or activities undertaken While on the Business of the Policyholder but unrelated to furthering the business of the Policyholder.

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

- acrobatic or stunt flying
- racing
- any endurance tests
- any flight on a rocket-propelled or rocket-launched aircraft
- crop dusting
- crop seeding
- crop spraying
- fire fighting
- exploration
- pipe line inspection

- power line inspection
- any form of hunting
- bird or fowl herding
- aerial photography
- banner towing
- any test or experimental purpose
- any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Trip means a trip taken by an Insured which begins when the Insured leaves his or her residence or place of regular employment for the purpose of going on the trip (whichever occurs last), and is deemed to end when the Insured returns from the trip to his or her residence or place of regular employment (whichever occurs first). However, the trip is deemed to exclude any period of time during which the Insured is on an authorized leave of absence or vacation or travel to and from the Insured's place of regular employment. "Trip" does not include the Insured's trip to a location that extends for more than 60 days. Such a trip will be deemed to change the Insured's residence or place of regular employment to the new location.

We, **Us**, or **Our** refers to National Union Fire Insurance Company of Pittsburgh, Pa.

While on the Business of the Policyholder means while on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, but does not include any period of time: (1) while the Insured Person is working at his or her regular place of employment; (2) during the course of everyday travel to and from work; or (3) during an authorized leave of absence or vacation. If an Insured's assignment to a location exceeds 60 days, such assignment will be deemed to change the Insured's residence and regular place of employment to the new location.

COVERAGE EFFECTIVE DATE

Insurance will become effective as to each eligible person in consideration of the required premium payment on the later(est) of: (a) the Policy Effective Date; or (b) Date of Hire.

INSURED'S EFFECTIVE AND TERMINATION DATES

An Insured's coverage begins on the latest of: (1) the Policy Effective Date; (2) the date the person becomes a member of an Eligible Class of Persons; or (3) the Coverage Effective Date.

An Insured's coverage ends on the earliest of: (1) the date the Policy is terminated; (2) the premium due date if premiums are not paid when due; or (3) the date the Insured ceases to be a member of an Eligible Class.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under the Policy.

PREMIUM

Premiums. The Company provides insurance in return for premium payments. The premium shown in the Schedule is payable to the Company in the manner described in the Schedule. The Company may change the required premiums due on any Policy anniversary date after the third Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 31 days advance written notice. The Company may also change the required premiums at any time when any coverage change affecting premiums is made in the Policy.

Grace Period. A Grace Period of 31 days will be provided for the payment of any premium due after the first. An Insured Person's coverage will not be terminated for nonpayment of premium during the Grace Period if all premiums due are paid by the last day of the Grace Period. An Insured Person's coverage will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the Grace Period.

If the Company expressly agrees to accept late payment of a premium without terminating coverage under the Policy, the Company does so in accordance with the Noncompliance with Policy Requirements provision of the General Provisions section.

No Grace Period will be provided if the Company receives notice to terminate the Insured Person's coverage under the Policy prior to a premium due date.

DESCRIPTION OF COVERED HAZARDS

The following Hazards apply only to Insured Persons in Classes as indicated in the Table of Hazards, Benefits, and Riders.

H-12 24-Hour Accident Protection While On a Trip (Business Only)

This Hazard applies only with respect to an Injury sustained by an Insured Person:

1. While on the Business of the Policyholder; and
2. during the course of any Trip, including a Sojourn or Personal Deviation taken during the course of the Trip, made by such person.

With respect to a Sojourn or Personal Deviation, this Hazard applies only where the Sojourns or Personal Deviations:

1. if they involve travel, do not depart more than 100 miles from the direct route or destination(s) with respect to the circumstances described herein; and
2. if they involve one or more stops en route and/or an extension of time spent at the destination(s) with respect to the circumstances described herein, do not last longer than a total of:

   (a) 7 day(s); or
   (b) 50% of the time that would otherwise have been spent under the circumstances described herein;

   whichever is less.

With respect to any period of time such Insured Person is traveling on a conveyance during the course of any such trip, this Hazard applies only with respect to Injury sustained by the person:

1. while operating or riding in or on (including getting in or out of, or on or off of), or by being struck or run down by any conveyance being used as a means of land or water transportation, except:

   a. any such conveyance the Insured Person has been hired to operate or for which the Insured Person has been hired as a crew member and while the Insured Person is performing as an operator or crew member on any such conveyance; or
   b. any such conveyance the Insured Person is operating, or for which the Insured Person is performing as a crew member, (including getting in or out of, or on or off of) for the transportation of passengers or property for hire, profit or gain; or

2. while riding as a Passenger in or on (including getting in or out of, or on or off of):

   a. any Civilian Aircraft; or
   b. any Military Air Transport Aircraft; or

3. by being struck or run down by any aircraft.

Exclusions. Exclusion 2 in the General Exclusions section is waived with respect to an Insured Person to whom this Hazard applies, but only with respect to Injury sustained by such person under the circumstances described in this Hazard. It is not waived with respect to such person traveling or flying in or on (including getting in or out of, or on or off of) any aircraft other than as expressly described in this Hazard, unless otherwise provided by the Policy.

In addition to all other exclusions in the General Exclusions, the circumstances described in this Hazard are deemed to exclude travel or flight in or on (including getting in or out of, or on or off of) any Policyholder Aircraft, unless otherwise provided by the Policy, and any aircraft while it is being used for Specialized Aviation Activity(ies).

DESCRIPTION OF BENEFITS

Principal Sum. As applicable to each Hazard and Benefit for each Insured Person, Principal Sum means the amount of insurance in force under the Policy on that person for that Hazard and Benefit as described for the Insured Person's Eligible Class in the Principal Sums section and in the Table of Hazards, Benefits and Riders.

Reduction Schedule. The amount payable for a loss will be reduced if an Insured Person is age 70 or older on the date of the accident causing the loss with respect to any Benefit provided under the Policy where the amount payable for the loss is determined as a percentage of his or her Principal Sum. The amount payable for the Insured Person's loss under that Benefit is a percentage of the amount that would otherwise be payable, according to the following schedule:

AGE ON DATE OF ACCIDENT	PERCENTAGE OF AMOUNT OTHERWISE PAYABLE
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

Premium for an Insured Person age 70 or older is based on 100% of the coverage that would be in effect if the Insured Person were under age 70.

"Age" as used above, refers to the age of the Insured Person on the Insured Person's most recent birthday, regardless of the actual time of birth.

B-1 Accidental Death Benefit
If Injury to an Insured Person results in death within 365 days of the date of accident that caused the Injury, We will pay 100% of the Principal Sum indicated for that Insured Person's Eligible Class.

B-2 Accidental Dismemberment and Paralysis Benefit
If Injury results within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, We will pay the percentage of the Principal Sum shown below for that Loss:

For Loss of	Percentage of Principal Sum
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Paralysis	
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

"Quadriplegia" means the complete and irreversible paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs on the same side of the body. "Limb" means entire arm or entire leg.

If more than one Loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance. If by reason of an accident occurring while coverage is in force, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable, the loss will be covered under the terms of the Policy.

If the Insured Person's body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Insured Person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered accidental death within the meaning of the Policy.

B-4 Bereavement and Trauma Counseling Benefit

If an Insured Person suffers an accidental death or an accidental dismemberment or paralysis for which an Accidental Death or Accidental Dismemberment and Paralysis Benefit is payable, or if he or she goes into a coma for which a Coma benefit is payable, We will pay Covered Bereavement and Trauma Counseling Expenses that are due to his or her death or dismemberment or paralysis or coma. The Covered Bereavement and Trauma Counseling Expenses must be incurred within one year after the date of the accident causing such loss(es), up to a maximum of $50 per session for up to 10 sessions for the Insured Person and all of his or her Immediate Family Members combined with respect to all such losses caused by the same accident.

"Covered Bereavement and Trauma Counseling Expenses" means an expense that: (1) is charged for a Medically Necessary Bereavement and Trauma Counseling Session for the Insured Person and/or one or more of his or her Immediate Family Member(s) provided under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar counseling sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Medically Necessary Bereavement or Trauma Counseling Session" means any individual, joint or family mental health counseling session that: (1) is essential to assist the Insured Person and/or one or more Immediate Family Members in coping with the loss for which it is provided; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

Exclusions. In addition to the General Exclusions, Covered Bereavement and Trauma Counseling Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

B-6 Carjacking Benefit – Percent of Principal Sum

We will pay a benefit when the Insured Person suffers one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit, Coma Benefit as a result of a Carjacking of an Automobile while the Insured Person is operating, or riding as a passenger in, (including getting in or out of) such Automobile.

The amount payable is the lesser of: (1) $5,000; or (2) 10% of the largest benefit payable under any one of the Benefits specified above due to the Carjacking. Only one benefit is payable for all losses as a result of the same Carjacking.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

"Automobile" means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

"Carjacking" means taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying such Automobile

B-7 Coma Benefit
If Injury renders an Insured Person Comatose within 365 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, We will pay a monthly benefit of 1% of the Principal Sum. No benefit is provided for the first 30 days of Coma. The benefit is payable monthly as long as the Insured Person remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured Person ceases to be Comatose due to that Injury; (2) the date the Insured Person dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals 100% of the Principal Sum. We will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which We are liable when the Insured Person is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

We reserve the right, at the end of the first 30 consecutive days of Coma and as often as We may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at Our expense.

"Coma/Comatose" means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

B-13 Emergency Evacuation With Family Travel Benefit

We will pay for Covered Emergency Evacuation Expenses reasonably incurred if the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, up to a maximum of $1,000,000 for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's Injury or Emergency Sickness warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

Family Travel Benefit
Following an Emergency Evacuation for which an Emergency Evacuation benefit is payable under the Policy, We will pay for expenses reasonably incurred:

1. to return to their current place of primary residence, with an attendant if necessary, any of the Insured Person's Children who were accompanying the Insured Person when the Injury or Emergency Sickness occurred; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and

2. to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is confined if the Insured Person is alone and if the place of confinement is outside a 100 mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any benefits under this Benefit to be payable. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

The General Exclusions and the Exclusions section of each Hazard to which this Benefit applies do not apply with respect to this Benefit.

"Children" means unmarried children, including (1) natural and adopted children from the moment of birth; and (2) step, foster or adopted children from the moment of placement in the Insured Person's home, under age 25 and

primarily dependent on the Insured Person for support and maintenance. However, the age limit does not apply to a child who: (1) otherwise meets the definition of Children; and (2) is incapable of self-sustaining employment by reason of developmental disability or physical handicap. The term "adopted children" includes a child for whom the Insured has assumed a legal obligation for total or partial support of a child in anticipation of adopting such child.

"Covered Emergency Evacuation Expense(s)" means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Emergency Evacuation" means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness: (1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

"Emergency Sickness" means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom that would lead a prudent layperson to require immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and under the circumstances described in a Hazard (a) applicable to that person and (b) to which this Benefit applies. For purposes of this Benefit, any references to "Injury" in such a Hazard are deemed to be references to "Injury or Emergency Sickness."

"Medically Necessary Emergency Evacuation Service" means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.

"Transportation" means moving the Insured Person during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

B-16 Home Alteration and Vehicle Modification Benefit
If an Insured Person:

1. suffers an accidental dismemberment or paralysis for which an Accidental Dismemberment and Paralysis benefit is payable;
2. did not, prior to the date of the accident causing such loss(es), require the use of a wheelchair to be ambulatory; and
3. as a direct result of such loss(es) are now required to use a wheelchair to be ambulatory,

We will pay Covered Home Alteration and Vehicle Modification Expenses that are incurred within one year after the date of the accident causing such loss(es), up to a maximum of $10,000 for all such losses caused by the same accident.

"Covered Home Alteration and Vehicle Modification Expenses" means one-time expenses that:
1. are charged for:

    (a) alterations to the Insured Person's residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person; or

(b) modifications to a motor vehicle owned or leased by the Insured Person or modifications to a motor vehicle newly purchased for the Insured Person that are necessary to make the vehicle accessible to and/or driveable by the Insured Person; and

2. do not include charges that would not have been made if no insurance existed; and
3. do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the Insured Person's residence and the modifications to his or her motor vehicle are:

1. made on the Insured Person's behalf;
2. recommended by a nationally-recognized organization providing support and assistance to wheelchair users;
3. carried out by individuals experienced in such alterations and modifications; and
4. in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Exclusions. In addition to the General Exclusions, Covered Home Alteration and Vehicle Modification Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

B-25 Rehabilitation Benefit

If an Insured Person suffers an accidental dismemberment or paralysis for which an Accidental Dismemberment and Paralysis Benefit is payable, We will reimburse the Insured Person for Covered Rehabilitative Expenses that are due to the Injury causing the dismemberment or paralysis. The Covered Rehabilitative Expenses must be incurred within two years after the date of the accident causing that Injury, up to a maximum of $10,000 for all Injuries caused by the same accident.

"Hospital" means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a Hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the Hospital that is used for such purposes; or (3) any military or veterans Hospital or soldiers home or any Hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

"Medically Necessary Rehabilitative Training Service" means any medical service, medical supply, medical treatment or Hospital confinement (or part of a Hospital confinement) that: (1) is essential for physical rehabilitative training due to the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

"Covered Rehabilitative Expense(s)" means an expense that: (1) is charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and (3) does not include charges that would not have been made if no insurance existed.

Exclusions. In addition to the Exclusions in the General Exclusions, Covered Rehabilitative Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

B-26 Repatriation of Remains Benefit
If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, We will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $1,000,000.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for Transportation of the remains; and (3) Transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. We reserve the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

"Emergency Sickness" means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom that would lead a prudent layperson to require immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and under the circumstances described in a Hazard (a) applicable to that person and (b) to which this Benefit applies. For purposes of this Benefit, any references to "Injury" in such a Hazard are deemed to be references to "Injury or Emergency Sickness".

B-28 Seat Belt and Air Bag (Percentage of Principal Sum Amount)

Seat Belt Benefit. We will pay a benefit when the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the accident causing death occurs while the Insured Person is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt. The amount payable under this Benefit is the lesser of: (1) $25,000; or (2) 10% of the Insured Person's Principal Sum.

Air Bag Benefit. We will pay an additional benefit under this Benefit if a Seat Belt Benefit is payable under this Benefit and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable under this Benefit is the lesser of: (1) $10,000; or (2) 5% of the Insured Person's Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

"Automobile" means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

LIMITATIONS

Limitation on Multiple Benefits. If an Insured Person suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits, the maximum amount payable under all Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment and Paralysis Benefit, Coma Benefit.

GENERAL EXCLUSIONS

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury:

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.

2. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a Passenger, pilot, operator or crew member, unless specifically provided by the Policy.

3. declared or undeclared war, or any act of declared or undeclared war.

4. sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.

5. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.

6. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to Us within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to Us at A&H Claims Department, PO Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify the Insured Person, is deemed notice to Us.

Claim Forms. We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to Us within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as We may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person’s beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee’s property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at Our option, to any relative by blood or connection by marriage of the payee, who, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person’s affairs.

Any payment We make in good faith fully discharges Our liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon Our receipt of due written proof of the loss. Subject to Our receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which We are liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

GENERAL PROVISIONS

Entire Contract; Changes. The Policy, the Master Application, and any attached papers make up the entire contract between the Policyholder and the Company. 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.

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

Incontestability. After an Insured Person has been insured under the Policy for two years during his or her lifetime, no statement by the Insured Person, except a fraudulent one, will be used to contest a claim under the Policy. We may only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person's beneficiary.

Legal Actions. No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Beneficiary Designation and Change. The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured for the Policyholder's group life insurance policy as shown on the Policyholder's records kept on that policy, unless the Insured has named a beneficiary specifically this Policy as shown on the Policyholder's records kept on the Policy.

An Insured over the age of majority and legally competent may change his or her beneficiary designation at any time, unless an irrevocable designation has been made, without the consent of the designated beneficiary(ies), by providing the Policyholder with a written request for change. When the request is received by the Policyholder, whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to Us on account of any payment made by it prior to receipt of the request.

If there is no designated beneficiary for an Insured's coverage or no designated beneficiary for the Insured's coverage is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: the Insured's (1) spouse; (2) Domestic Partner; (3) children; (4) parents; or (5) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

Physical Examination and Autopsy. We, at Our own expense, have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as We may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity With State Statutes. Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Workers' Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

Assignment. An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her designated beneficiary. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Misstatement of Age. If premiums for the Insured Person are based on age and the Insured Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

PROTECTION FOR YOU AND YOUR INSURANCE POLICY
THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

The Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32A RCW ("Act"). Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex officio, oversee the operation of the Association.

The expenses of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance Guaranty Association P.O. Box 2292 Shelton, WA 98584 360-426-6744	Company Supervision Division Office of the Insurance Commissioner P.O. Box 40259 Olympia, WA 98504-0259 360-725-7214

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

   The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance," as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance" (which includes long term care policies). Together, all of these policies and contracts are sometimes referred to as "covered policies," a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

   The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued

in Washington by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

3. WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:

- You are a Washington resident; or
- You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the time of entry of an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as

authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The Association generally cannot make an assessment for covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits.....$500,000

Disability Benefits and Health Benefits (including Long Term Care Benefits).....$500,000

Present Value of Individual Annuities $500,000

Unallocated Annuity Contracts, other than certain government retirement plans (limit is per contract owner or plan sponsor) $5,000,000

Government Retirement Plans established under Internal Revenue Code §§ 401, 403(b), or 457 (limit is per participant).....$100,000

This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

You should not rely on coverage under the Act when selecting an insurance company.

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This brochure has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by this brochure, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.