

Group Accident Policy



ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

In return for the payment of premium expressed in the **Schedule**, **We** agree to pay the benefits of this Group **Accident Policy** to the persons insured hereunder, subject to the terms and conditions, which follow. **We** have issued the Group **Accident Policy** to the **Policyholder**. The Group **Accident Policy** is executed as of the **Policy** date which is its date of issue, and from which anniversary dates are measured. The Group **Accident Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

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

POLICYHOLDER: Iowa League of Cities
317 Sixth Avenue, Suite 1400
Des Moines, IA 50309

POLICY NUMBER: GTU 2815756

POLICY DATE: January 1, 2011 to Continuous
(All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

As of January 1, 2011, this **Policy** replaces the prior **Policy** effective November 1, 1998, bearing the same **Policy** number.

CONTRACT SITUS: Iowa

The following pages, including any riders, endorsements, schedule pages, **Insured** enrollment forms, applications or amendments, are a part of this Group **Accident Policy**. **We** and the **Policyholder** have agreed to all the terms of this Group **Accident Policy**.

This is a legal contract between the **Policyholder** and **Us**.
READ THE GROUP ACCIDENT POLICY CAREFULLY

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

Nancy D. Mueller
President
Zurich American Insurance Company

Dennis F. Kerrigan, Jr.
Corporate Secretary
Zurich American Insurance Company

NON-PARTICIPATING

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SECTION I – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

ELIGIBILITY AND CLASSIFICATION OF INSURED:

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

- Class I:** All Volunteer Firefighters, First Responders, Paramedics, EMTs and other Volunteer Rescue Staff who are members in good standing and who appear on the Membership Roster on file with the City Clerk or Fire Chief who have a completed enrollment form on file with the **Policyholder**.
- Class II:** All **Class I** eligible Members and their **Spouse/Domestic Partner** who have a completed enrollment form on file with the **Policyholder**.
- Class III:** All **Class I** eligible Members, their **Spouse/Domestic Partner** and all **Dependent Child(ren)** who have a completed enrollment form on file with the **Policyholder**.
- Class IV:** All **Class I** eligible Members and their **Dependent Child(ren)** who have a completed enrollment form on file with the **Policyholder**.

It is understood and agreed that whenever the word "Employee" is used in this **Policy**, it shall be understood to include a Member of the **Policyholder**.

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF INSURED'S DEPENDENTS:

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

EFFECTIVE DATE OF INSURANCE FOR THE INSURED:

- A. For eligible individuals hired prior to January 1, 2011:
January 1, 2011, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.
- B. For eligible individuals hired on or after January 1, 2011:
On the first day of the month following the date the completed enrollment material is received by the **Policyholder**.

SECTION II – SCHEDULE

COVERAGE(S):

24 Hour **Accident** Protection, Business and Pleasure,
Excluding Corporate Owned or Leased Aircraft, H-1
Exposure and Disappearance Coverage

Classes Covered

All

All

BENEFITS:

Accidental Death Benefit

Classes Covered

All

Principal Sum:

Class I: \$20,000 Primary **Insured** Member
Class II: \$20,000 Primary **Insured** Member
\$10,000 **Spouse/Domestic Partner**
Class III: \$20,000 Primary **Insured** Member
\$ 8,000 **Spouse/Domestic Partner**
\$ 2,000 **Dependent Child(ren)**
Class III: \$20,000 Primary **Insured** Member
\$ 3,000 **Dependent Child(ren)**

BENEFITS continued

Classes Covered

Accidental Dismemberment and Plegia Benefit

All

Principal Sum:

Same as above.

Coma Benefit

All

ADDITIONAL BENEFITS:

Classes Covered

Additional Dismemberment Benefit for Children
Carjacking Benefit
Day Care Benefit
Hearing Aid or Prosthetic Appliance Benefit
Higher Education Benefit
Home Alteration and Vehicle Modification Benefit
Rehabilitation Benefit
Spouse/Domestic Partner Retraining Benefit
Therapeutic Counseling Benefit

All

All

All

All

All

All

All

All

All

ADDITIONAL ENDORSEMENTS

Form Number

Classes Covered

Safety Device Benefit

U-VA-112-A (CW) (02/09)

All

Enrollment Required:

Yes

Premium Due Date:

Forty-five (45) days after the anniversary date of the **Policy**

Premium: Member Only: \$13.30 per year
Member & **Spouse/Domestic Partner** Only: \$19.00 per year
Member & **Dependents** (Family): \$19.00 per year
Member & **Dependent Children** Only: \$19.00 per year

These rates are guaranteed until January 1, 2014.

This **Policy** requires a minimum annual premium of \$250 per fire department.

SECTION III – DEFINITIONS

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

Active and **Actively at Work** describes 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.

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

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

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

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

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

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

Covered Person means any person who has insurance under the terms of this **Policy**. It includes the **Insured** and his or her **Spouse/Domestic Partner** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse/Domestic Partner** and/or **Dependent Child(ren)** is selected.

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

Dependent Child(ren), if used in this **Policy**, means those unmarried **Child(ren)** of the **Insured**, and those unmarried **Child(ren)** of his or her legally married **Spouse**, and those unmarried **Child(ren)** of the **Insured's Domestic Partner** who rely on the **Insured** for more than 50% of their support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 25 (twenty-five) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

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

Injury means a bodily **Injury**.

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

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

SECTION III – DEFINITIONS continued

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

Policy means this Group **Accident Insurance Policy**.

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

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

acrobatic or stunt flying	hang gliding
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	
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 **Insured's** legally married **Spouse**. A **Spouse** will only be a **Covered Spouse** if a **Plan** covering the **Insured's Spouse** is selected.

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

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

SECTION IV – COVERAGES

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

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

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

Hazard Limitations:

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

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

Hazard Exclusions:

Coverage is not provided:

- A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft.
- B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
 - 1. any aircraft other than those expressly stated in this **Coverage**;
 - 2. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**.
 - 3. any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured** or a member of a **Covered Person's** family or household;
 - 4. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
 - 5. any aircraft engaged in a **Specialized Aviation Activity**;
 - 6. any conveyance used for tests or experimental purposes, or in a race or speed test.

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

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

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

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

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

ACCIDENTAL DISMEMBERMENT AND PLEGIA BENEFIT

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

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

Covered Loss of	Benefit
1. Both Hands or Both Feet	Principal Sum
2. One Hand and One Foot	Principal Sum
3. One Hand or One Foot plus the loss of Sight of One Eye	Principal Sum
4. Sight of Both Eyes	Principal Sum
5. Speech and Hearing	Principal Sum
6. Speech or Hearing	50% of Principal Sum
7. One Hand; One Foot; or Sight of One Eye	50% of Principal Sum
8. Thumb and Index Finger of the same Hand	25% of Principal Sum
Plegia	Benefit
1. Quadriplegia (total paralysis of all four Limbs)	Principal Sum
2. Triplegia (total paralysis of three Limbs)	75% of Principal Sum
3. Paraplegia (total paralysis of both lower Limbs)	66 2/3% of Principal Sum
4. Hemiplegia (total paralysis of upper and lower Limbs on one side of the body)	50% of Principal Sum
5. Uniplegia (total paralysis of one Limb)	25% of Principal Sum

For purposes of this benefit:

1. **Covered Loss** means:
 - a. For a foot or hand, actual severance through or above an ankle or wrist joint;
 - b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
 - c. Total and permanent loss of sight;
 - d. Total and permanent loss of speech;
 - e. Total and permanent loss of hearing.
2. **Plegia** must continue for twelve (12) consecutive months and be determined by **Our** competent medical authority to be permanent, complete and irreversible paralysis of one or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

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

COMA BENEFIT

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

The **Coma Benefit** will be payable at 1% of the **Covered Person's Principal Sum** per month for the first 11 months the **Covered Person** remains in a **Coma**, following the initial thirty-one (31) day period. At the end of the 11 months of payment, if the **Covered Person** remains in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the **Accidental Death Benefit** less the amount of the 11 months of benefit already received.

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

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

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If the **Insured** selects a **Plan** covering his or her eligible **Dependent Child(ren)**, and a **Covered Dependent Child** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment Benefit**, **We** will pay the **Insured** an additional benefit which will be equal to the benefit amount provided by the **Accidental Dismemberment Benefit**.

CARJACKING BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death or Accidental Dismemberment and Plegia Benefit**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the **Covered Person** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to 15% of the applicable **Principal Sum** to a maximum of \$20,000.

Verification of the **Carjacking** must be made part of an official police report within twenty-four (24) hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24) hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than the **Covered Person** taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

DAY CARE BENEFIT

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

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

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

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

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

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

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

An **Accredited Child Care Facility** means:

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

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

HEARING AID OR PROSTHETIC APPLIANCE BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Plegia Benefit**, **We** will pay an additional benefit provided:

1. the **Covered Person** is required to use a hearing aid or prosthetic appliance;
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Plegia Benefit** is the same **Injury** that requires the **Covered Person** to use the **Hearing Aid or Prosthetic Appliance**; and
3. the **Hearing Aid or Prosthetic Appliance** was required within one (1) year of the **Injury**.

The amount **We** will pay will be equal to the one time cost of the **Hearing Aid or Prosthetic Appliance** actually paid by the **Covered Person**.

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified physician or surgeon who is not the **Covered Person's** spouse, child, or relative; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this benefit, **Prosthetic Appliance** will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of 15% of the **Covered Person's Principal Sum** or \$10,000.

HIGHER EDUCATION BENEFIT

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

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

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

The **Higher Education Benefit** will be equal to 15% of the **Insured's Principal Sum**, to a maximum of \$25,000 per year. This amount will be paid annually for four (4) consecutive years if the **Covered Dependent Child** continues his or her education. Before this benefit is paid each year, the **Covered Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.

The maximum amount payable under this benefit is \$100,000.

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

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

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

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

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

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

Benefits will not be payable unless:

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

The maximum amount payable under all provisions of this benefit combined will be the lesser of 15% of the **Covered Person's Principal Sum** or \$50,000.

REHABILITATION BENEFIT

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

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. \$20,000; or
3. 10% of the **Insured'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 **Insured's Injury**; and
3. prepares the **Insured** 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**.

SPOUSE/DOMESTIC PARTNER RETRAINING BENEFIT

If an **Insured** selects a **Plan** covering his or her **Spouse/Domestic Partner** and the **Insured** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, **We** will pay to his or her **Covered Spouse/Domestic Partner**, the actual cost of any professional or trade-training program in which the **Covered Spouse/Domestic Partner** enrolls, provided:

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

The maximum amount payable under this benefit will be \$25,000.

THERAPEUTIC COUNSELING BENEFIT

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her **Covered Dependents** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death** or **Accidental Dismemberment and Plegia Benefit**, and the **Insured** or his or her **Covered Dependents** requires **Therapeutic Counseling**, **We** will reimburse the charges for such counseling, to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;
3. **Therapeutic Counseling** must be received within one (1) year from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is \$5,000 for any one **Covered Accident**.

SECTION VII – GENERAL EXCLUSIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
2. war or any act of war, whether declared or undeclared;
3. involvement in any type of active military service;
4. illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity;
7. travel or flight in any aircraft except to the extent stated in the **Coverage** Section.

SECTION VIII – GENERAL LIMITATIONS

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

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

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

SECTION IX - TERMINATION OF INSURANCE

A. Policy Termination.

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

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

B. Termination of Individual's Insurance.

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

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

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

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

Conversion Privilege

If the insurance of an **Insured** ceases for reasons other than termination of the **Policy** or nonpayment of premium, the **Insured** is entitled to convert his or her **Coverage** to an **Individual Accidental Death or Dismemberment (IAD)** policy or to a **Family AD&D (FAD)** policy if the **Insured** selected a **Plan** covering his or her **Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the Group **Accident Policy**. The **Insured** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of insurance under the Group **Accident Policy**. To request a Conversion Application Form, the **Insured** must call 1-800-834-1959. The **Insured** does not have to show proof of good health.

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

1. the **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of the **Insured's Principal Sum** under the Group **Accident Policy** or \$100,000;
2. the premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any **IAD** or **FAD** policy issued will take effect on the termination date of the **Insured's** insurance under the Group **Accident Policy**; and
4. when an **IAD** or **FAD** policy becomes effective, the relationship between the **Insured** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

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

SECTION X - HOW TO FILE A CLAIM

- A. Notice.** The **Insured** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, the **Insured**, and the **Policy** Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.
- B. Claim Forms.** **We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and 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**.
- C. Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss**, and the proof was provided as soon as reasonably possible.

SECTION XI - PAYMENT OF CLAIMS

- A. Time of Payment.** **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which 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**.
- B. Who We Will Pay.**
1. Loss of Life of an **Insured**. **Covered Losses** resulting from the **Insured'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 **Insured**, **We** will pay the benefit to the **Insured's** estate.
 2. Loss of Life of a **Covered Person** other than the **Insured**. **Covered Losses** for the death of a **Covered Person** other than the **Insured** will be paid to the **Insured**. If the **Insured** pre-deceases or dies at the same time as the **Covered Person** other than the **Insured**, 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 **Insured's** estate.
 3. All Other Claims. Benefits are to be paid to the **Covered Person**.
- C. Physical Examination and Autopsy.** **We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- D. Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

SECTION XII - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** The **Insured** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Insured** 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**.
- B. 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.
- C. Clerical Error.** A clerical error or omission will not increase or continue an **Insured's Coverage**, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. 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.
- E. Entire Contract.** This **Policy**, the **Policyholder** application, **Insured** enrollment materials, and any attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. Grace Period.** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If the **Policyholder** does not pay a renewal 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 not have a **Grace Period** if **We** have given notice, at least thirty (30) days in advance, that **We** are going to terminate this **Policy**.
- G. Insured Certificates.** **We** will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Insureds**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**. Such **Certificate** will contain a summary of terms that affect benefits.
- H. Policyholder Records.** The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. 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.
- I. 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 **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- J. 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.
- K. 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** 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.
- L. 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.

Iowa League of Cities
GTU 2815756
Effective: January 1, 2011

AMENDATORY ENDORSEMENT
Safety Device Benefit



ZURICH AMERICAN INSURANCE COMPANY
Schaumburg, Illinois

This endorsement, effective January 1, 2011, forms a part of **Policy** No. GTU 2815756, issued to Iowa League of Cities.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Group Accident Policy.

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

SECTION II – SCHEDULE is amended to include the following:

ADDITIONAL BENEFITS:
Safety Device Benefit

Classes Covered
ALL

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

SAFETY DEVICE BENEFIT

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

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

Continued

Endorsement No. 1
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Safety Device Benefit continued

- g. an **Approved Ski Helmet** while the **Covered Person** is engaged in downhill skiing or snowboarding, after purchasing a valid lift ticket and skiing/snowboarding during normal operating hours and on the marked premises of the facility selling the lift ticket.
- h. an **Approved Equestrian Helmet** while the **Covered Person** is engaged in horseback riding.
- i. an **Approved Protective Helmet** while the **Covered Person** is actively at work.
- j. **Approved Body Armor** while the **Covered Person** is actively at work.

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

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

SAFETY DEVICE BENEFIT DEFINITIONS:

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

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

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

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

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

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

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

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

Endorsement No. 1
(Page 2 of 2)

Signed for by Zurich American Insurance Company



Date: January 1, 2011