ARCH INSURANCE COMPANY

(A Missouri Corporation)

Home Office Address:
2345 Grand Blvd
Suite 900
Kansas City, MO 64108

Administrative Address:
11350 McCormick Road
Executive Plaza IV
Suite 102
Hunt Valley, MD 21031
Tel: 855-951-2329

CALIFORNIA INDIVIDUAL ACCIDENT POLICY

Policyholder	SAMPLE POLICY			
Policy Number				
Policyholder Mailing Address				
Policy Period	Effective Date		Expiration Date	
	12:01 A.M. Standard Time at Mailing Address of the Policyholder			
State of Delivery	California			

The Policy takes effect at 12:01 A.M. of the Policy Period Effective Date shown above. It will remain in effect for the duration of the Policy Period shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:01 A.M., on the Policy Period Expiration Date.

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

THIS IS AN ACCIDENT ONLY POLICY. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED BY FEDERAL LAW.

LIMITED BENEFITS: THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES DURING THE COVERED ACTIVITIES SHOWN IN THE SCHEDULE OF BENEFITS ONLY. PLEASE READ THE POLICY CAREFULLY.

NOTICE

THIS NOTICE IS TO ADVISE THE POLICYHOLDER THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING THIS POLICY, YOU MAY CONTACT ARCH INSURANCE COMPANY AT 11350 MCCORMICK ROAD, EXECUTIVE PLAZA IV SUITE 102, HUNT VALLEY, MD 21031 OR CALL 888-259-3236.

ALSO AVAILABLE IS THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA DEPARTMENT OF INSURANCE, WHICH MAY BE CONTACTED AS FOLLOWS: CALIFORNIA DEPARTMENT OF INSURANCE CONSUMER SERVICES DIVISION; 300 SPRING STREET, SOUTH TOWER, LOS ANGELES, CALIFORNIA 90013 OR CALL 1-800-927-HELP OR 1-800-927-4357.

THE DEPARTMENT OF INSURANCE SHOULD BE CONTACTED ONLY AFTER DISCUSSIONS WITH THE INSURANCE COMPANY OR ITS REPRESENTATIVES HAVE FAILED TO PRODUCE A SATISFACTORY RESOLUTION TO THE PROBLEM.

Required Disclosure under California Insurance Code 10270.3: Please note that all benefits payable under this Policy may be subject to reduction, to the extent provided in this Policy, to the extent that you are entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group or blanket insurance policy or contract, hospital or medical service program, or group-practice pre-payment plan, except for automobile medical payments insurance.

THIS POLICY IS NOT RENEWABLE.

IN WITNESS WHEREOF, Arch Insurance Company has caused this policy to be executed and attested as of the Effective Date shown above.

Patrick K. Nails
Secretary

John Mentz
President

INDEX OF POLICY PROVISIONS

A. THINGS YOU SHOULD KNOW

When does my coverage begin and end?

You are covered under this policy on the Effective Date shown on the Schedule of Benefits after:

- You have applied for coverage;
- We have approved Your application; and
- You have paid the required premium.

Your coverage ends on the Expiration Date shown on the Schedule of Benefits, subject to any prior cancellation by you or us.

Are there any significant and unusual exclusions or limitations?

These are all set out full in the policy wording, but please note the following:

- This policy is excess over any other medical, health, or accident coverage available.
- The insurance excludes any known pre-existing medical conditions.
- There is an exclusion for losses arising from war or terrorism and from firearms and explosives.

How do I file a claim?

Claims are administered by Arch Insurance Company. You have five options for filing a claim under this policy: online, by phone, by fax, by mail, or by email. Choose the method that's best for you.

For faster claim service, we recommend filing a claim online. To file a claim online, go to:
https://accidentclaims.archinsurancesolutions.com

You will need your Arch Individual Accident Policy number and last name to create a claim. Please have electronic copies of your receipts available.

Our claims team is available 9:00 A.M. - 9:00 P.M. EST

Online: https://accidentclaims.archinsurancesolutions.com

By Phone: 855-951-2329

By Email: claims@archinsurancesolutions.com

By Fax: 443-279-2901

By Mail: Claims Department
Arch Insurance Solutions Inc.
Executive Plaza IV
11350 McCormick Road, Suite 102
Hunt Valley, MD 21031

Additional claim provisions are explained in section G. How to File a Claim.

B. SCHEDULE OF BENEFITS

INDIVIDUAL ACCIDENT INSURANCE SCHEDULE OF BENEFITS				
Policyholder Name	*Policyholder name*		Policy Number	*Policy number*
Policyholder Mailing Address	*Mailing address*		Policyholder Email Address	*email*
Policy Period	Effective Date		Expiration Date	
	12:01 A.M. Standard Time at the Mailing Address of the Policyholder			
Policy Premium	$ 14.00			
The Policy Premium is based on the rates currently in force and on the limits of the insurance and benefits in effect.				

COVERED PERSON AND COVERED ACTIVITIES	
Policyholder Covered Activity	Spectator at Your Child's Covered Activity
Your Child's Name	*childs name*
Your Child's Age at Policy Effective Date	*age*
Your Child's Covered Activity	*sport*
Organization Sponsoring Your Childs' Covered Activity	*organization*
Subject to all of the terms and conditions of the policy, benefits described in the policy are payable when **you** or **your child** suffers a **loss** as a result of an **accident** during a **covered activity**.	

BENEFITS, LIMIT OF INSURANCE AND DEDUCTIBLE	
Benefits	**Limit of Insurance**
POLICYHOLDER - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	$10,000
POLICYHOLDER - ACCIDENT MEDICAL EXPENSE REIMBURSEMENT FULL EXCESS	$0
YOUR CHILD - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	$10,000
YOUR CHILD - ACCIDENT MEDICAL EXPENSE REIMBURSEMENT FULL EXCESS	$5,000
Regardless of the number of **accidents** or covered **injuries** that occur during the **policy period, our** total limit of insurance for the **policy period** for all coverage and benefits provided under this policy shall not exceed the amounts shown above. For more details on the Limit of Insurance and Deductible, please see section F. LIMITS OF INSURANCE AND DEDUCTIBLES	

C. POLICY DEFINITIONS

Some words or phrases in the policy have been defined below. Defined words or phrases are printed in **bold** and have the following meanings, unless a different meaning is described in a particular coverage.

You, Your — The Policyholder as shown on the Schedule of Benefits.

We, Us, Our — Arch Insurance Company, the company providing this insurance.

Child — **Your** dependent child, including a natural child, stepchild, or a child placed with you for adoption or foster care, who is under the age of 26 at the inception of the policy, shown on the Schedule of Benefits and for which a premium has been paid.

Accident — A sudden, unforeseeable event during the **policy period** causing **injury** to **you** or your **child**.

Actual Cost(s) — The standard costs and fees a **physician** would charge, regardless of whether that customer or patient has insurance coverage.

Brain Death — Irreversable unconsiousness with total loss of brain function; and complete absence of electrical activity of the brain, although the heart is still beating.

Covered Activity — The activity(ies) shown on the Schedule of Benefits that takes place during the **policy period** and within the **coverage territory**.

Coverage Territory — The United States, its territories and possessions.

Hemiplegia — Total **paralysis** of the upper and lower limbs on one side of the body.

Injury(ies) — Bodily harm caused by an **accident** that occurs during the **policy period**. All injuries sustained in one **accident**, including all related conditions and recurring symptoms of the injuries will be considered one injury.

Loss — An eligible benefit occuring during the **policy period**.

Limit of Insurance — The most **we** will pay under this policy for the coverage and benefits as shown on the Schedule of Benefits.

Medical Expenses — The following expenses **you** incur for the **treatment** that **you** or your **child** receives to treat a covered **injury**:

1. Medical services (including charges for anesthetics, x-ray examinations or treatments, and laboratory tests) and supplies, prescription drugs, and theraputic services ordered or prescribed by a **physician**;
2. Hospital or ambulatory medical-surgical center services; and
3. Local ambulance services to and/or from a hospital.

Medically Necessary — **Medically Necessary** means:

1. A treatment, service or supply that is require to treat an **injury**;
2. Prescribed or ordered by a **physician** or furnished by a hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for **treatment** of the condition at the time rendered.

The purchasing or renting of air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered **medically necessary**.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it **medically necessary** or covered by this Policy.

Member

Loss of Hand or Foot, Loss of Sight, Loss of Speech and Loss of Hearing. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total and permanent loss of sight of one or both eye(s) that is irrecoverable, including by surgical and artificial means. "Loss of speech" means total and permanent loss of coherent audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

Other Valid and Collectible Insurance

Any reimbursement for or recovery of any element of **Medical Expenses** incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Any amount payable for hospital, medical or other health services for the accidental bodily inury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to **your** job to the extent that **you** actually recieved benefits under a Workers' Compensation Law. If **you** enters into a settlement to give up **your** rights to recover future medical expenses that would have been payable except for that settlement.
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to **you** after **you** become disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Paralysis

Total loss of use.

Paraplegia

Total **paralysis** of both lower limbs.

Physician

A person who is a qualified practitioner of medicine. Such person must be acting within the scope of his/her license and under the laws in the state in which he or she practices and must be providing only those medical services which are within the scope of his/her license or certificate. Such person cannot be **you** nor a family member.

Policy Period(s)

The period specified on the Schedule of Benefits, subject to any cancellation prior to the scheduled expiration.

Pre-existing Condition(s)

An **injury**, illness, disease or other condition that in the 24-month period before this coverage became effective:

1. First manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinary or prudent person to seek diagnosis, care or treatment; or
2. Required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. Was treated by a **physician** or **treatment** had been recommended by a **physician**.

Preventative

Any treatment, service or procedure, including but not limited to physical examinations, medications, surgeries, incoculations or laboratory procedures, for the purpose of prevention of **injury** or for the promotion of general health, where there has been no **injury**.

Quadriplegia

Total **paralysis** of both upper and lower limbs.

Treatment(s)

Any **medically necessary** medical care administered and medications requiring a prescription that are prescribed by a **physician**, or under a **physician's** direct supervision, in treating **your** or **your child's injury**.

Uniplegia

Total paralysis of one lower limb or one upper limb.

D. BENEFIT PROVISIONS

Upon **your** payment of the premium when due, and in reliance of the statements **you** made in the application, **we** will provide coverage as specifically described in this policy for **you** and for **your child** listed on the Schedule of Benefits. Unless stated to the contrary, all benefits are subject to all the terms, conditions, exclusions and limitations as stated herein and as shown on the Schedule of Benefits.

1. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT: If **you** or **your child** sustain an **injury** as a result of an **accident** while participating in a **covered activity** that results in any of the **losses** shown in the table below, **we** will pay the percentage of the Principal Sum shown in the Schedule of Benefits for this benefit. If **you** or **your child** suffer more than one **loss** from the same **accident**, **we** will only pay the largest amount. Loss of life must occur within three hundred sixy-five (365) days of the **accident** for the Accidental Death benefit to apply.

Loss:	% of the Principal Sum:
Life	100%
Brain Death	100%
Quadriplegia	100%
Two or More **Members**	100%
One **Member**	50%
Hemiplegia	50%
Paraplegia	50%
Uniplegia	25%
Thumb and Index Finger of Same Hand	25%
Four Fingers of the Same Hand	25%

2. ACCIDENT MEDICAL EXPENSES REIMBURSEMENT BENEFIT: **We** will reimburse **you**, up to the **limit of insurance**, the **actual cost(s)** of **medical expenses** incurred by **you** for the **treatment you** or **your child** receives for an **injury** caused by an **accident** while participating in a **covered activity**. The **treatment** must be adminstered or prescribed within ninety (90) days of **your** or **your child's injury** to be eligible for reimbursement.

FULL EXCESS PROVISION Insurance provided by this policy for this benefit shall be excess of all **other valid and collectible insurance**. If at the time of the **injury** there is **other valid and collectible insurance** or indemnity in place, **we** shall be liable only for the excess of the amount of loss, over the amount of such other insurance or indemnity. Recovery of losses from other parties does not result in a refund of premium paid.

E. WHAT WE DO NOT COVER

1. This policy does not cover:
   i. Any **loss** if **you** have not complied with all conditions related to coverage set forth in this policy;
   ii. Any **pre-existing condition**;
   iii. **Treatment** rendered outside the **coverage territory**;
   iv. Experimental or elective **treatment**, routine physical examinations, hearing aids, eye glasses, contacts or hearing aids.
2. **We** will not reimburse **you** for any **injury** caused by, arising out of or related to, directly or indirectly, any of the following:
   i. An **accident** or **injury** that occured before **you** and **your child** are covered by this policy;
   ii. An **accident** or **injury** that occured outside the **coverage territory**;
   iii. Sickness, disease, or mental, nervous or psychological disorder or infirmity, including any medical or surgical treatment thereof;
   iv. Intentionally self-inflicted **injury**, suicide or attempted, while sane or insane;
   v. Participation in any kind of sporting or leisure activity for compensation or profit, including coaching or officiating;
   vi. Participation in a **covered activity** against medical advice;
   vii. **You** or **your child** traveling to or from the **covered activity**, including traveling to and from practice or special events related to the **covered activity**;
   viii. Being under the influence of alcohol or narcotics, unless administered on the advice of a **physician**, or performance-enhancing drugs;
   ix. **Injury** occuring after the **policy period**;
   x. **Injury** from any person's use of firearms or explosives;
   xi. War, invasion, acts of foreign enemies, hostilities between nations (whether declared or undeclared), or civil war; or an act of terrorism.

F. LIMITS OF INSURANCE

1. LIMITS OF INSURANCE: Regardless of the number of **accidents** or covered **injuries** that occur during the **policy period**, **our** total limit of insurance for the **policy period** for all coverage and benefits provided under this policy shall not exceed the amount shown on the Schedule of Benefits.

G. CLAIM PROVISIONS

1. NOTICE OF CLAIM: Notice of a claim must be reported to **us** within twenty (20) days after the **accident** occurs or the **treatment** is provided, whichever is later, or as soon thereafter as is reasonably possible. **You** or someone on **your** behalf may give notice. The notice should provide sufficient information to identify **you**.

2. CLAIM FORM: When notice of claim is received by **us**, the forms for filing proof of loss will be furnished. If such forms are not furnished within fifteen (15) days after receipt of **your** notice, the proof of loss requirements can be met by **you** sending **us** a written statement of what happened. This statement must be received within the time given for filing proof of loss.

3. PROOF OF LOSS: Written proof of loss must be furnished to **us** within ninety (90) days after the date of such loss.

The following documentation must be submitted with the claim form:

i. Receipts from the providers of service, stating the amount paid and listing the diagnosis and treatment;
ii. Provide a copy of the final disposition of **your** claim under **your** primary medical or health insurance or other primary accident insurance; and
iii. A copy of the death certificate, applicable only for an Accidental Death claim.

Failure to furnish such proof within the time required shall not invalidate nor reduce 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 **your** legal capacity, later than one year from the time proof is otherwise required.

4. PAYMENT OF LOSS: Once **you** or **your** beneficiary have provided written proof of loss, **we** will pay any benefits due to **you** or to **your** beneficiary, or **your** estate if no beneficiary has been designated, within thirty (30) days from the date of **our** receipt of all required information. This payment will include the effect of the **deductible** calculations and deducted non-coverable items, if applicable and any **limits of insurance**. **We** cannot preauthorize or guarantee coverage of a claim. Please keep in mind, **you** are financially responsible to the health service provider for payment of all **treatment**.

5. THE BENEFICIARY: **You** decide who receives the benefits of this policy if **you** die. **You** should have named a beneficiary on **your** application form. If **you** named more than one person but didn't tell **us** what their shares should be, they will share equally. If someone **you** named dies before **you**, that person's share will be divided equally by the beneficiaries still alive, unless you have specified otherwise.

The right to change a beneficiary is reserved to **you** and the consent of the beneficiary or beneficiaries shall not be requisite to any change of beneficiary or beneficiaries, or to any other changes in this policy. **You** are the beneficiary for **your child**.

6. EXAMINATION AND AUTOPSY: **We** have the right to have a **physician** of **our** choice at **our** own expense examine the person for who the claim is being made under this policy. And, where allowed by law, **we** have the right to have an autopsy performed at **our** expense prior to the payment of benefits under this policy, unless the law forbids it.

7. COOPERATION: Failure of a claimant to cooperate with **us** in the administration of a claim may result in the delay of termination of benefits. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

8. MEDICAL REVIEW REQUIREMENTS: **You** may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if **you** believe that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under coverage that has been denied modified, or delayed by us, in whole or in part because the service is not **medically necessary,** within six months of the denial. The CA commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension. The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR.
You have the right to provide information in support of the request for an IMR. The informations may include the

following:

1. A provider recommendation indicating that the disputed health care service is **medically necessary** for the insured's medical condition.
2. Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for **your** medical condition.
3. Reasonable information supporting **your** position that the disputed health care service is or was **medically necessary** for **your** medical condition, including all information provided to **you** by **us** or any of its contracting providers, still in **your** possession, in support of the grievance, as well as any additional material that **you** believe is relevant.

We must provide **you** with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause **you** to forfeit any California statutory right to pursue legal action against **us** regarding the disputed health care service. It should be noted that **we** do not believe any such California statutory right exists which is applicable to it. The form also must include signed insured's consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any non-contracting provider the insured may have consulted on the matter. This form will also include an optional section to collect information on **you or your child's** ethnicity, race, and primary language spoken for statistical purposes only, in order to ensure that everyone get the best care possible. The decision to not provide this information will not affect the IMR process in any way.

For more information regarding the IMR process, or to request an application form, please contact **us** or **the CA Department of Insurance at 1-800-927-4357, or through their Internet Web site, www.insurance.ca.gov.**

Eligibility. The California Department of Insurance will review **your** application for an IMR to confirm that:

1. The provider has recommended a health care service as **medically necessary**.
    i. **You** or **Your Child** has received urgent care or emergency services that a provider determined was medically necessary; or
    ii. **You** or **Your Child** has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review.
2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not **medically necessary**; and
3. **You** filed a grievance with **us** and the disputed decision is upheld or the grievance remains unsolved after thirty (30) days. If the grievance requires expedited review, **you** may bring it up immediately to the attention of the California Department of Insurance. It may waive the requirement that **you** follow the *plan's* grievance process in extraordinary and compelling cases.

If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is **medically necessary**. **You** will receive a copy of the assessment made. If the IMR determines the service is **medically necessary**, **we** will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the California Department of Insurance must provide its determination within thirty (30) days of receipt of **your** application and supporting documents. For urgent cases involving an imminent and serious threat to **you** or **your child's** health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of **you** or **your child's** health, the IMR organization must provide its determination within three (3) business days.

H. GENERAL CONDITIONS

1. FREE LOOK PERIOD - 10 DAYS: When the initial policy is received, if **you** are not satisfied with the policy, **you** may return it to **us** within ten (10) days of the initial coverage effective date. **We** will then cancel this policy and refund the premium in full, as long as **you** have not filed a claim.

2. CANCELLATION:

i. **You** may cancel this policy at any time by returning it to **us** or by notifying **us** in writing of the effective date of the future cancellation.
   a. If **you** notify **us** within the first thirty (30) days from the effective date shown on the Schedule of Benefits, and **you** have not submitted any claim against this policy, **we** will refund the entire premium.
   b. If **you** cancel this policy after it has been in effect for thirty (30) days, **we** will return the pro rata premium based on the date of termination of this policy.

ii. If this policy has been in effect for less than sixty (60) days, **we** may cancel the policy for any reason.

iii. If this policy has been in effect for sixty (60) days or more, **we** may cancel the policy for only the following reasons:
   a. Nonpayment of premium;
   b. A loss or a substantial decrease in reinsurance;
   c. **Your** material failure to comply with policy terms and conditions;
   d. A substantial change in the condition, factor, or loss experience material to insurability (except that a material change in **you** or **your child's** health does not constitute a change that would provide grounds for cancellation of the policy); or
   e. **You** materially misrepresent or exaggerate relevant information pertaining to this policy or a claim.

iv. If **we** cancel this policy for nonpayment of premium, **we** will send written notice to **you** at least fifteen (15) days before the effective date of cancellation. If **we** cancel this policy for any other reason, **we** will send written notice to you at least thirty (30) days before the effective date of the cancellation.

v. If this policy is cancelled by **us**, **we** will promptly return to **you** the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim occuring prior to the date of cancellation.

vi. This policy is non-renewable at expiration. To obtain another policy, you must submit another application for a quote.

3. CONCEALMENT, MISREPRESENTATION OR FRAUD: **We** are not obligated to provide coverage under this policy if **you** at any time intentionally conceal, misrepresent or exaggerate a material fact concerning:

i. This policy;
ii. **You** or **your child**; or
iii. A claim under this policy.

The falsity of any statement **you** make shall not bar the right to recovery under the policy unless such false statement was made with actual intent to decieve or unless it materially affected either the acceptance of the risk or the hazard assumed by **us**.

4. CONFORMITY TO STATE STATUTES: Any policy provision which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery, is amended to conform to the minimum requirements of such statute.

5. ENTIRE POLICY: This policy, the Schedule of Benefits, the application and any endorsements contain all the agreements between **you** and **us**. The terms may not be changed or waived except by an endorsement issued by **us** and made a part of this policy.

6. ELECTRONIC DELIVERY: It is agreed that, unless otherwise notified by **you**, all written documents and communications regarding this policy, its endorsements, and any notices may be delivered to **you** by electronic mail using the email address associated with **your** policyholder account, except documents required to be delivered by another method. It is further agreed that it is **your** responsibility to keep **your** contact details, including email, telephone and postal address, current and correct.

7. LEGAL ACTIONS: No one may bring a legal action against **us** until there has been full compliance with all the terms of this policy. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. **You** will have three (3) years from the time written proof of loss is required to be furnished to take legal action against **us** with respect to recovery of a claim under this policy.

8. OUR RIGHT TO RECOVER PAYMENT: We reserve the right to recover from **you** any benefits **we** have paid for **injuries** received for a covered accident under:

1. Workers' Compensation or similar statutory remedies available under law; or
2. Any employer's liability insurance.