UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way, Eatontown, New Jersey 07724
(Hereinafter referred to as "the Company")

TRAVEL PROTECTION INSURANCE

CONFIRMATION OF BENEFITS

Benefit	Maximum Benefit Amount/Principal Sum

Part A – Travel Arrangement Protection
Trip Interruption..$10,000
Travel Delay (Up to $200 Per Day)...............................$600
Baggage and Personal Effects $1,000
Vehicle Disablement……………………………………$1,500

Part B – Travel Insurance Benefits
Accident & Sickness Medical
Expense (after $250 deductible)…………………….. $5,000
Non-Emergency Medical Evacuation………..……..$100,000

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TRAVEL PROTECTION INSURANCE

Certificate of Insurance

This Certificate of Insurance describes all of the travel insurance benefits underwritten by United States Fire Insurance Company, herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Benefits. It provides the Insured with specific information about the program he or she purchased. The Insured should contact the Company immediately if he or she believes that the Confirmation of Benefits is incorrect.

Insurance provided by this Certificate is subject to all of the terms and conditions of the Group Policy. If there is a conflict between the Policy and Certificate, the Policy will govern.

If the Insured is not completely satisfied with the insurance he or she must notify the Company within 15 days of purchase and return the certificate. The Company will give the Insured a full refund of premium provided he or she has not already departed on the Covered Trip or filed a claim.

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COVERAGE A
ACCIDENT MEDICAL EXPENSE

This Coverage A Benefit is provided only if shown as covered on the Confirmation of Benefits.

For purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1) the services of a Legally Qualified Physician;
2) Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of an Injury);
3) transportation furnished by a professional ambulance company to and/or from a Hospital; and prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of an accidental Injury, which occurs during the Covered Trip. An Insured must receive initial Medical Treatment for the Injury within 30 days after the date of the accident, which caused the Injury. All services, supplies or treatment must be received within the 52 weeks following the date of the accident.

Benefits will include expenses for emergency dental treatment for Injury to sound natural teeth not to exceed $1000.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, because of a covered accidental Injury. The authorized travel assistance company will coordinate advance payment to the Hospital.

Dispatch of a Physician: If the local attending Legally Qualified Physician and the authorized travel assistance company cannot adequately assess Your need for Medical Evacuation or Transportation, and a Physician is dispatched by the authorized travel assistance company to make such assessment, benefits will be paid for the travel expenses incurred and medical services provided by the dispatched Physician.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE B
SICKNESS MEDICAL EXPENSE

This Coverage B is made a part of the policy to which it is attached. It is subject to all policy provisions of this Coverage B.

For purposes of this benefit:

"Covered Expense" means expense incurred for services and supplies: (a) listed below; and (b) ordered or prescribed by a Legally Qualified Physician as Medically Necessary for diagnosis or treatment; which are limited to:

1) the services of a Legally Qualified Physician;
2) Hospital or ambulatory medical-surgical center services (this will also include expenses for a cruise ship cabin or hotel room, not already included in the cost of the Insured's Covered Trip, if recommended as a substitute for a hospital room for recovery of an Sickness);
3) transportation furnished by a professional ambulance company to and/or from a Hospital; and
4) prescribed drugs, prosthetics and therapeutic services and supplies.

Benefits will be paid for the expense incurred, up to the Maximum Benefit Amount, if an Insured incurs a Covered Expense as a result of Sickness, which manifests itself during the Covered Trip. An Insured must receive initial Medical Treatment for the Sickness within 30 days of onset of the Sickness. All services, supplies or treatment must be received within the 52 weeks following the onset of the Sickness.

Benefits will include expenses for emergency dental treatment for Injury to sound natural teeth not to exceed $1000.

Benefits will not be paid in excess of the Usual and Customary Charges.

Advance payment will be made to a Hospital, up to the Maximum Benefit Amount, if needed to secure an Insured's admission to a Hospital, up to the Maximum Benefit Amount, because of a covered Sickness. The authorized travel assistance company will coordinate advance payment to the Hospital.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE C
TRIP INTERRUPTION

This Coverage C Benefit is provided only if shown as covered on the Confirmation of Benefits.

Benefits will be paid, up to the Maximum Benefit Amount, for the non-refundable, unused portion of the prepaid expenses for Travel Arrangements and/or the additional cost for one way Economy Transportation for the Insured to return to their original destination or rejoin their Trip less the value of the original unused return travel ticket when an Insured is prevented from completing his or her Trip due to:

1) Death of an Insured, Traveling Companion or Family Member of an Insured or Traveling Companion;
2) A covered Sickness or Injury involving an Insured, Traveling Companion, Family Member of an Insured or Traveling Companion which necessitates Medical Treatment at the time of interruption and results in medically imposed restrictions, as certified by a Legally Qualified Physician, which prevents an Insured's continued participation in the Covered Trip;

3) An Insured's or Traveling Companion's principal place of residence being rendered uninhabitable by unforeseen circumstances or fire or flood or burglary of primary residence during the Insured's Covered Trip;
4) An Insured or Traveling Companion being directly involved in a traffic accident, which must be substantiated by a police report, while en route to an Insured's scheduled point of departure;
5) Natural disaster at the site of the Insured's destination, which renders their destination accommodations uninhabitable;

Provided such circumstances occurred after the Insured's Effective Date and during the Insured's Covered Trip.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE D
BAGGAGE AND PERSONAL EFFECTS

This Coverage D Benefit is provided only if shown as covered on the Confirmation of Benefits.

For purposes of this benefit:

"Baggage and Personal Effects" means goods being used by an Insured during a Covered Trip. The term Baggage and Personal Effects does not include:

a) animals;
b) automobiles and automobile equipment;
c) boats or other vehicles or conveyances;
d) trailers;
e) motors;
f) aircraft;
g) bicycles, except when checked as baggage with a Common Carrier;
h) household effects and furnishings;
i) antiques and collectors items;
j) sunglasses, contact lenses, artificial teeth, dental bridges or hearing aids;
k) prosthetic limbs;
l) prescribed medications;
m) keys, money, credit cards (except as coverage is otherwise specifically provided herein);
n) securities, stamps, tickets and documents (except as coverage is otherwise specifically provided herein);
o) professional or occupational equipment or property, whether or not electronic business equipment; or
p) telephones, computer hardware or software;

For Baggage and Personal Effects: Coverage will be provided to an Insured: (a) against all risks of permanent loss, theft or damage to baggage and personal effects; (b) subject to all Exclusions and Limitations in the policy; (c) up to the Maximum Benefit Amount; and (d) occurring while this coverage is in force.

The lesser of the following amounts will be paid:

a) the actual cash value (cost less proper deduction for depreciation) at the time of loss, theft or damage;
b) the cost to repair or replace the article with material of a like kind and quality; or
c) $300 per article.

A combined maximum of $600 will be paid for jewelry, watches, articles consisting in whole or in part of silver, gold or platinum, articles trimmed with fur, cameras and their accessories and related equipment.

A maximum of $50 will be paid for the cost of replacing a passport or visa.

A maximum of $50 will be paid for the cost associated with the unauthorized use of lost or stolen credit cards, subject to verification that the Insured has complied with all conditions of the credit card company.

For Baggage Delay: If, while on a Covered Trip, an Insured's checked baggage is delayed or misdirected by a Common Carrier for more than 24 hours from his or her time of arrival at a destination other than at his or her place of permanent residence, benefits will be paid, up to the Maximum Benefit Amount, for the actual expenditure for necessary personal effects. An Insured must be a ticketed passenger on a Common Carrier. The Common Carrier must certify the delay or misdirection. Receipts for the purchases must accompany any claim.

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the Common Carrier, hotel or Travel Supplier; nor will benefits be paid for loss or damage to property specifically schedule under any other insurance.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE E
TRIP DELAY

This Coverage E Benefit is provided only if shown as covered on the Confirmation of Benefits.

If an Insured is delayed for 12 or more hours while en route to or from or during a Covered Trip, due to:

a) any delay of a Common Carrier. The delay must be certified by the Common Carrier;
b) a traffic accident in which an Insured or Traveling Companion are not directly involved (must be substantiated by a police report);
c) lost or stolen passports, travel documents or money (must be substantiated by a police report); or
d) quarantine, hijacking, Strike, natural disaster, or riot;
e) documented weather condition preventing the Insured from getting to the point of departure;

benefits will be paid, on a one-time basis, up to the Maximum Benefit Amount, for:

a) the Additional Transportation Cost from the point where an Insured was delayed to a destination where he or she can join the Covered Trip;
b) the Additional Transportation Cost to return an Insured to his or her originally scheduled return destination, reasonable accommodation and meal expenses up to $200 per day necessarily incurred by an Insured for which he or she has proof of purchase and which were not paid for or provided by any other source; and
c) the non-refundable, unused portion of the prepaid expenses for the Covered Trip as long as the expenses are supported by proof of purchase and are not reimbursable by any other source.

Benefits will not be paid for any expenses that have been reimbursed or for any services that have been provided by the Common Carrier.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE F
EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATIONAND RETURN OF REMAINS

This Coverage F Benefit is provided only if shown as covered on the Confirmation of Benefits.

When an Insured suffers loss of life for any reason or incurs a Sickness or Injury during the course of a Covered Trip, the following benefits are payable, up to the Maximum Benefit Amount.

1) For **Emergency Medical Evacuation**: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

For **Non-Emergency Medical Evacuation**: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

If an Insured is in the Hospital for more than seven consecutive days the Company will pay to return by Economy Transportation, the Insured's dependent children who are under 18 years of age and accompanying an Insured on the Covered Trip, to their home, with an attendant, if considered necessary by the travel assistance company.

If an Insured is in a Hospital alone for more than 7 consecutive days and Emergency Evacuation is not imminent, upon request of the Insured or next of kin if Insured is incapacitated, the Company will pay to transport one person, chosen by the Insured, by Economy Transportation, for a single visit to and from his or her bedside.

2) For **Medical Repatriation**:
   a) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for an Insured to return to his or her place of permanent residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for an Insured's return to his or her permanent residence via:
      i. one-way Economy Transportation; or
      ii. commercial upgrade, based on an Insured's condition as recommended by the local attending Legally Qualified Physician and verified in writing.

      Transportation must be via the most direct and economical route.

   b) If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for an Insured to return to his or her place of permanent residence for continued treatment of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred will be paid for transportation to the Hospital or medical facility closest to an Insured's permanent place of residence capable of providing that treatment. Transportation must be by the most direct and economical route. Covered land or air transportation includes, but is not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company.

3) For **Return of Remains**: In the event of an Insured's death, the expense incurred will be paid for minimally necessary casket or air tray, preparation and transportation of an Insured's remains to his or her place of residence or to the place of burial.

If benefits are payable under this Coverage F and an Insured has other insurance that may provide benefits for this same loss, the Company reserves the right to recover from such other insurance. An Insured shall:
a) notify the Company of any other insurance;
b) help the Company exercise the Company's rights in any reasonable way that the Company may request, including the filing and assignment of other insurance benefits;
c) not do anything after the loss to prejudice the Company's rights; and
d) reimburse to the Company, to the extent of any payment the Company has made, for benefits received from such other insurance.

Benefits are paid less the value of the Insured's original unused return travel ticket.

These benefits will not duplicate any benefits payable under the policy or any coverages provided herein.

The Maximum Benefit Amount is shown in the Confirmation of Benefits.

COVERAGE G
VEHICLE DISABLEMENT

The Company will reimburse You for actual expenses incurred, up to the Maximum Benefit Amount shown on the Confirmation of Benefits if, during Your Covered Trip, Your vehicle sustains a collision or mechanical failure that prevents it from being driven. We will reimburse You for the following:

a) transportation expenses for You to return to Your primary residence;
b) any reasonable expenses for meals and lodging (including local transportation and essential phone calls) incurred as a result of Your vehicle's disablement;
c) the cost to repair the immediate cause of the disablement during Your Trip of Your vehicle.

For purpose of this Vehicle Disablement Benefit, Covered Trip shall mean any Covered Trip at least fifty (50) miles from Your primary residence.

The following Exclusions apply to this Vehicle Disablement Benefit:

a) Theft or vandalism of Your vehicle;
b) Any loss to or arising from a commercial or non-private passenger vehicle.

This Vehicle Disablement Benefit does not reimburse for any services covered by a roadside assistance company.

SECTION II. DEFINITIONS

"Additional Transportation Cost" means the actual cost incurred for one-way Economy Transportation by Common Carrier reduced by the value of an unused travel ticket.

"Common Carrier" means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

"Confirmation of Benefits" means the coverage confirmation provided to an Insured following enrollment and payment of the applicable premium.

"Covered Trip" means scheduled trips, tours or cruises for which (a) coverage is requested: and (b) the required premium is submitted prior to the Scheduled Departure Date.

"Economy Transportation" means the lowest published available transportation rate for a ticket on a Common Carrier matching the original class of transportation that the Insured purchased for the Covered Trip, reduced by the value of an unused return travel ticket."

"Family Member" means any of the following who resides in the United States, Canada, or Mexico: an Insured's or an Insured's Traveling Companion's: legal spouse (or common-law spouse where legal), legal guardian, son or daughter (adopted, foster, step or in-law), brother or sister (includes step or in-law), parent (includes step or in-law), grandparent (includes in-law), grandchild, aunt, uncle, niece or nephew, domestic partner, an employed caregiver who lives with the Insured, or a person for whom the Insured is the primary caregiver with whom the Insured have lived for 12 continuous months prior to the effective date of the Insured's Plan, whether or not they travel with the Insured.

"Hospital" means (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located: (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals. Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Injury" or "Injuries" means accidental bodily injuries: (a) received while insured under the Policy and any attached coverages: (b) resulting in loss independently of sickness and all other causes: (c) requires examination and treatment by a Legally Qualified Physician and (d) not excluded from coverage.

“’Insured” means the individual named on the enrollment form who has purchased a Covered Trip and who has paid the required premium.

“Intoxicated” mean a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where an Insured is located at the time of an incident.

“Legally Qualified Physician” means a physician or a Christian Science Practitioner (a) other than an Insured, a Traveling Companion or a Family Member: (b) practicing within the scope of his or her license: and (c) recognized as a physician in the place where the services are rendered.

“Maximum Benefit Amount” means the maximum amount payable for coverage provided to an Insured as shown in the Confirmation of Benefits.

“Medical Treatment” means treatment advice or consultation by a Legally Qualified Physician.

“Medically Necessary” means a service or supply which: (a) is recommended by the attending Legally Qualified Physician: (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice: (c) could not have been omitted without adversely affecting an Insured’s condition or quality of medical care: (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience: and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

“Pre-existing Condition” means any injury, sickness or condition (including any condition from which death ensues) of the Insured, or Traveling Companion, or the Insured’s and/or Traveling Companion’s Family Member for which within the 60 day period prior to the effective date of the Insured’s Trip Cancellation coverage under the Policy which (a) manifested itself, became acute or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Legally Qualified Physician.

“Scheduled Departure Date” means the date on which an Insured is originally scheduled to leave on the Covered Trip.

“Scheduled Return Date” means the date on which an Insured is originally scheduled to return to the point of origin or the original final destination.

“Sickness” means an illness or disease that is diagnosed or treated by a Legally Qualified Physician after the effective date of insurance and while the Insured is covered under the Policy.

“Strike” means any stoppage of work: (a) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased: and (b) which interferes with the normal departure and arrival of a Common Carrier.

“Third Party” means a person or entity other than an Insured or the Company.

“Transportation Expense” means: (a) the cost of conveyance of an Insured and any medical personnel (if Medically Necessary): and (b) Medically Necessary services or supplies.

“Travel Arrangements” means: (a) transportation: (b) accommodations: and (c) other specified services arranged for the Covered Trip.

“’Traveling Companion” means a person or persons with whom the Insured has coordinated Travel Arrangements and intends to travel with during the Covered Trip. Note, a group or tour leader is not considered a Traveling Companion unless the Insured is sharing room accommodations with the group or tour leader.

“Travel Supplier” means any entity or organization that coordinates or supplies travel services for an Insured.

“Usual and Customary Charges” means those comparable charges for similar treatment, services and supplies in the geographic area where treatment is performed.

SECTION III. INSURING PROVISIONS

Insured's Term of Coverage:

For Trip Delay: Coverage is in force while traveling more than 50 miles from Your primary residence en route to and from the Covered Trip.

For all other coverages: Coverage begins at the point and time of departure on the Scheduled Departure Date. Coverage ends at the point and time of return on an Insured's Scheduled Return Date.

SECTION IV. GENERAL LIMITATIONS AND EXCLUSIONS

Benefits are not payable for Sickness, Injuries or losses of an Insured, his or her Traveling Companion, Insured's or Traveling Companion's Family Member:

1) resulting from suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (in Missouri, sane only);
2) resulting from an act of declared or undeclared war;
3) while participating in maneuvers or training exercises of an armed service;
4) while riding, driving or participating in races, or speed or endurance contests;
5) while mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
6) while participating as a member of a team in an organized sporting competition;
7) while participating in skydiving, hang gliding, bungee cord jumping, scuba diving if the depth exceeds 120 feet or if the Insured is not certified to dive and a dive master is not present during the dive or deep sea diving;
8) received as a result or consequence of being Intoxicated, as specifically defined in the policy, or under the influence of any controlled substance unless administered on the advice of a Legally Qualified Physician;
9) to which a contributory cause was the commission of or attempt to commit a felony or being engaged in an illegal occupation;
10) due to normal childbirth, normal pregnancy through the first 6 months of pregnancy or voluntarily induced abortion;
11) Due to a mental or nervous condition, unless hospitalized;
12) for dental treatment (except as coverage is otherwise specifically provided herein);
13) which exceed the Maximum Benefit Amount for each attached coverage as shown in the Confirmation of Benefits: or;
14) due to a Pre-existing Condition, as defined in the Policy. The Pre-existing Condition Limitation does not apply to: (a) Emergency Medical Evacuation, Medical Repatriation and Return of Remains coverage;
15) due to loss or damage (including death or injury) and any associated cost or expense resulting directly from the discharge, explosion or use of any device, weapon or material employing or involving chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act and regardless of any other sequence thereto.

Additional Limitations and Exclusions Specific to Baggage and Personal Effects

Benefits are not payable for any loss caused by or resulting from:

a) breakage of brittle or fragile articles;
b) wear and tear or gradual deterioration;
c) confiscation or appropriation by order of any government or custom's rule;
d) theft or pilferage while left in any unlocked vehicle;
e) property illegally acquired, kept, stored or transported;
f) an Insured's negligent acts or omissions; or
g) property shipped as freight or shipped prior to the Scheduled Departure Date.

SECTION V. GENERAL PROVISIONS

Notice of Claim: Notice of claim must be reported within 20 days after a loss occurs or as soon as is reasonably possible. An Insured or someone on an Insured's behalf may give the notice. The notice should be given to the Company or designated representative and should include sufficient information to identify the Insured.

Claim Forms: When notice of claim is received by the Company or designated representative, forms for filing proof of loss will be furnished. If these forms are not sent within 15 days, the proof of loss requirements can be met by sending a written statement of what happened. This statement must be received within the time given for filing proof of loss.

Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

Time of Payment of Claims: The Company or its designated representative will pay the claim after receipt of acceptable proof of loss.

Payment of Claims: Benefits for loss of life are payable to the Principal Insured, who is the beneficiary for all other Insureds. If: (a) the Principal Insured predeceases an Insured: and (b) a beneficiary is not otherwise designated by the Principal Insured benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

a) the Principal Insured's spouse;
b) the Principal Insured's child or children jointly;
c) an Insured's parents jointly if both are living or the surviving parent if only one survives;
d) an Insured's brothers and sisters jointly; or
e) the Principal Insured's estate.

All or a portion of all other benefits provided by the Policy may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Principal Insured.

Other than for loss of life, if any benefit is payable to: (a) an Insured or the Principal Insured's beneficiary who is minor or otherwise not able to give a valid release: or (b) the Principal Insured's estate: the Company may pay up to $1,000.00 to the Principal Insured's beneficiary or any relative to whom the Company finds entitled to the payment. Any payment made in good faith shall fully discharge the Company to the extent of such payment.

Physician Examination and Autopsy: The Company, at the expense of the Company, may have an Insured examined when and as often as is reasonable while the claim is pending. The Company may have an autopsy done (at the expense of the Company) where it is not forbidden by law.

Legal Actions: No legal action for a claim can be brought against us until 60 days after we receive proof of loss. No legal action for a claim can be brought against us more than 3 years after the time required for giving proof of loss. This 3-year time period is extended from the date proof of loss is filed and the date the claim is denied in whole or in part.

Concealment and Misrepresentation: The entire coverage will be void, if before, during or after a loss, any material fact or circumstance relating to this insurance has been concealed or misrepresented.

Other Insurance with the Company: An Insured may be covered under only one travel policy with the Company for each Covered Trip. If an Insured is covered under more than one such policy, he or she may select the coverage that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. Premiums paid (less claims paid) will be refunded for the duplicate coverage that does not remain in effect.

Subrogation: If the Company has made a payment for a loss under this coverage, and the person to or for whom payment was made has a right to recover damages from the Third Party responsible for the loss, the Company will be subrogated to that right. An Insured shall help the Company exercise the Company's rights in any reasonable way that the Company may request: nor do anything after the loss to prejudice the Company's rights: and in the event an Insured recovers damages from the Third Party responsible for the loss, the Insured will hold the proceeds of the recover for the Company in trust and reimburse the Company to the extent of the Company's previous payment for the loss.

Additional Claims Provisions Specific to Baggage

Insured's Duties After Loss of or Damage to Property or Delay of Baggage: In case of loss, theft, damage or delay of baggage or personal effects, and Insured must:

a) take all reasonable steps to protect, save or recover the property:
b) promptly notify, in writing, either the police, hotel proprietors, ship lines, airlines, railroad, bus, airport or other station authorities, tour operators or group leaders, or any Common Carrier or bailee who has custody of an Insured's property at the time of loss:
c) produce records needed to verify the claim and its amount ,and permit copies to be made:
d) provide to the Company, within 90 days from the date of loss, a detailed proof of loss signed and sworn to: and
e) be examined, if requested.

Reductions in the Amount of Insurance: The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid for any loss or damage under this coverage for this Covered Trip.

UNITED STATES FIRE INSURANCE COMPANY
AMENDATORY ENDORSEMENT
New Hampshire Residents

This endorsement is made a part of the Certificate to which it is attached. This endorsement is subject to all of the provisions and limitations of the Policy and the Certificate. If there is a conflict between the Policy, Certificate, and the endorsement, the terms of the endorsement will govern.

The certificate to which this endorsement is attached is amended as follows:

1) The definition of “Family Member” is amended to read:

   “Family Member” means an Insured’s or a Traveling Companion’s: legal spouse or common-law spouse where legal; legal guardian; son or daughter (adopted, foster or step); child placed for adoption with the Insured or Traveling Companion; son-in-law; daughter-in-law; grandmother; grandmother-in-law; grandfather; grandfather-in-law; grandchild; aunt; uncle; niece; or nephew; brother, step-brother; sister; step-sister; brother-in-law; sister-in-law; mother; father; step-parent.

2) The definition of “Hospital”, is amended to read:

   “Hospital” means (a) a place that operates according to law in the state where it is located; and b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility: Not included is a hospital or institution licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics: or (2) as a clinic continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

3) The provision entitled “Proof of Loss” is amended to read:

   Proof of Loss: Proof of loss must be provided within 90 days after the date of the loss or as soon as is reasonably possible.

GRIEVANCE PROCEDURES
(Applicable to Residents of NEW HAMPSHIRE Only)

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

If you have a complaint about a claim denial, you, your authorized representative, or a provider acting on your behalf may call our [Customer Services department at 1-800-xxx-xxxx] to informally resolve your complaint. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to further explain the issue or immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5-business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 15-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

In the event of an Adverse Determination, you, your authorized representative, or a provider acting on your behalf may submit a formal Grievance within 180-days following receipt of the Adverse Determination.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

In the event you fail to submit all information needed to decide the appeal. We will notify you in writing of precisely what is required. You will have 45-days within which to respond to our request and provide sufficient information. If you fail to provide the necessary information within that timeframe, we may deny the appeal on the basis of incompleteness.

Internal First Level Review

Within 3-working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, an Internal First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 30-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the Internal First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request an External Second Level Review, if applicable, and a description of the procedure and timeframes for requesting an External Second Level Review and options for bringing a legal action.

External Second Level Review

The External Second Level Review process is available if you are not satisfied with the outcome of the Internal First Level Review for an Adverse Determination or if you have requested an Informal or Internal First Level Review and did not receive a decision from the Company within the time frames allowed for such reviews. Within 10-business days after receiving a request for an External Second Level Review, we or our designated utilization review organization will provide you and the selected independent review organization with the following:

(1) The name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) A statement of your rights, including the right to:
    - Attend the External Second Level Review;

- Present his/her case to the review panel;
- Submit supporting materials before and at the review meeting;
- Ask questions of any member of the review panel;
- Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney;
- Request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination;

(3) A copy of your health insurance contract, evidence of coverage, benefit summary, or similar document;
(4) All relevant medical records;
(5) A summary of the applicable issues, including a statement of our final determination;
(6) The clinical review criteria used and the clinical reasons for the determination;
(7) Any communications between you and us regarding the Informal or Internal First Level Review; and
(8) All other documents, information, or criteria relied upon by us in making our determination.

We will convene a review panel and hold a review meeting within 45-days after receiving a request for an External Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15-working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:
(1) Were not previously involved in any matter giving rise to the External Second Level Review;
(2) Are not employees of the Company or Utilization Review Organization; and
(3) Do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing an External Second Level Grievance involving a Utilization Review non-certification or a clinical issue must be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on an Internal First Level Review, we may use one of our employees on the External Second Level Review panel if the panel is comprised of 3 or more persons.

A written statement of the External Second Level Review panel's decision will be issued to you and, if applicable, to your representative or provider, within 10-business days after completing the review meeting. The decision will include:
(1) The name(s), title(s) and qualifying credentials of the members of the review panel;
(2) A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;

(3) The review panel's recommendation to the Company and the rationale behind the recommendation;
(4) A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) The rationale for the Company's decision if it differs from the review panel's recommendation;
(7) A statement that the decision is the Company's final determination in the matter;
(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, Internal First Level Review or External Second Level Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2-working business days of the decision and will contain the same items described in the written decision requirements for an Internal First Level Review.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective review of Adverse Determinations.

When used throughout this document "The Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

Long Distance Towing

A non-insurance benefit funded by Worldwide Rescue & Security, Inc. and coordinated by On Call, the authorized travel assistance service provider.

If You are traveling at least 50 miles away from home AND experience a vehicle breakdown AND Your vehicle breakdown is expected to Interrupt or Delay your Trip by at least 12 hours, Travel Shield™ will provide You with the following:

Travel Shield™ will arrange and pay up to the Maximum Benefit Amount for the one-way transport of Your automobile, motorcycle, or non-commercial truck from a local repair facility to Your choice of:

- Your Permanent Primary Residence; or
- Your place of rental; or
- Your Travel Destination

You are responsible for getting the vehicle to a local repair facility to diagnosis the issue. If it is then determined that repairs will take longer than 12 hours thereby Interrupting or Delaying Your Trip, You are responsible for contacting Travel Shield™ to activate the "Long Distance Towing" benefit.

This benefit works in conjunction with any existing roadside assistance coverage that may be available to You and in conjunction with the "Vehicle Disablement" coverage as defined within Your certificate.

The Maximum Benefit Amount is $1,500 per Policy Year. You are responsible for any costs exceeding the Maximum Benefit Amount. This benefit does not cover RV's. This benefit does not cover breakdowns as the result of a Motor Vehicle Accident.

Definitions:

"Travel Shield™" refers to Our program, services and benefits.

"On Call" means On Call International, the Travel Shield™ service provider.

"Our" and "Worldwide Rescue & Security, Inc." means and/or refers to the company that owns and operates the Travel Shield™ plan. The individual Insured relationships are the confidential property of the program.

"You" and "Your" means Insured, Spouse and Dependent(s).

"Spouse" means the Insured's spouse (to include legally recognized domestic partner), unless they are legally separated.

"Dependent" means the Insured's unmarried children from birth through age 18; or through age 22 if enrolled as a full-time student in an accredited college, university, vocational or technical school; or whose support is required by a court decree, or adult child(ren) or grandchild(ren) with mental or physical disabilities who are solely dependent for maintenance and support. Children include natural children, stepchildren and legally adopted children. They must be primarily dependent on the Insured for support and maintenance and must live in a parent-child relationship with the Insured. If traveling on a trip without the Insured, Dependents are covered provided the trip does not exceed ninety (90) days.

"Interrupt" or "Delay" means a vehicle disablement that prevents You from arriving at Your Travel Destination or Your Permanent Primary Residence.

“Permanent Primary Residence” means the locale of the address as shown on Your state driver’s license or state-issued identification card.

“Travel Destination” means the original final destination of Your Trip.

“Trip” means travel of at least 50 miles from Your Permanent Primary Residence during the Policy Year where Travel Arrangements have been reserved prior to departure on Your Trip.

“Travel Arrangements” means transportation, accommodations, and other specified services arranged for Your Trip.

“Maximum Benefit Amount” means the maximum amount payable for coverage provided to You.

“Policy Year” means the one-year period of time that begins with Your policy effective date and for which premium is paid.

“Motor Vehicle Accident” means the unintended collision of one motor vehicle with another, a stationary object, or person, resulting in injuries, death and/or loss of property.

CONDITIONS, LIMITATIONS AND EXCLUSIONS

The services described are available to You only during Your Policy Year and are available only when You are traveling more than 50 miles from Your Permanent Primary Residence. Expenses for the ”Long Distance Towing” benefit will be covered only if On Call has given prior approval and if those services are coordinated by On Call.

On Call has sole discretion in determining eligibility for the “Long Distance Towing” benefit. On Call will determine the appropriate method, vendor and timing of any vehicle transport. The destination will be chosen by You as described in the “Long Distance Towing” benefit.

On Call will only direct-pay and not reimburse You for any transport costs paid by You to the transportation providers, unless approved by On Call in advance. On Call is not responsible for the availability, quality, results of, or failure to provide any service caused by conditions beyond On Call’s control.

The Travel Shield™ plan, and all goodwill associated therewith, is owned and operated by Worldwide Rescue & Security, Inc. and the individual member relationships are the confidential property of the program.

ELIGIBILITY
A citizen or resident of the United States of America who has completed the enrollment form and paid the required premium. Eligibility will be determined at time of claim. If it is determined that a person or Trip is not eligible for coverage, any claim for benefits will be denied. Insured must be traveling on a covered Trip in order to be eligible for “Long Distance Towing” benefits.

The Travel Shield™ product consists of all benefits shown herein and benefits are not available for individual purchase.

Assistance Services

Non-insurance medical and travel assistance services are coordinated by On Call, the authorized travel assistance service provider. Services are available to You whenever you are traveling on a covered Trip.

Deposits, Advances and Guarantees: Deposits, advances and guarantees will be provided to medical facilities, hotels, airlines, ground and air ambulances and other like providers in order to secure service for You. Any advances of funds on Your behalf shall be charged to Your credit card at the time of service.

Pre-Travel Information: Upon Your request, We will provide You with destination intelligence regarding weather, travel, health, inoculations, travel restrictions and special events. This service is available to You prior to departing on a covered Trip.

Lost Luggage Assistance: We will assist You with the tracking of luggage lost in transit. If the luggage cannot be recovered, We will assist You with locating replacements.

Monitoring of Treatment: In an emergency, We will continually monitor Your condition while You are hospitalized and provide ongoing updates to Your family. Depending upon the medical and/or geographic situation, We may retain the services of licensed consulting physicians/nurses and/or other medical professionals with relevant areas of expertise to assist in the monitoring of Your condition.

Transfer of Insurance Information to Medical Providers: To help prevent delays or denials of medical care, We will assist You with hospital admission, such as relaying insurance benefit information. We will also assist with discharge planning.

Replacement of Corrective Lenses and Medical Devices: We will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen or broken during travel. You are responsible for all costs other than shipping. These expenses will be billed to Your credit card prior to shipping.

Continuous Updates to Family, Employer, and Physician: With Your approval, We will provide case updates to appropriate individuals you designate in order to keep them informed.

Emergency Travel Arrangements: In an emergency, We will help You change airline, hotel or car rental reservations as necessary.

Emergency Cash Advance Assistance: In an emergency, We will provide assistance to You by arranging for the forwarding of funds from Your account, credit cards or family members. All fees associated with the transfer of funds will be billed to Your credit card at the time of service.

Legal Referrals: If You are on a covered Trip and are arrested, involved in an accident, or otherwise require the services of an attorney, We will arrange for an initial telephone consultation with an attorney, without charge. We will also assist with the securing of a bail bond, if needed. If further legal assistance is needed, You will be referred to an attorney in the appropriate geographic area. Fees and costs charged by the referred attorney will be Your responsibility.

Translation Services: We will, without charge, provide foreign language assistance over the telephone or up to one-page translations submitted via fax. If necessary, We will also provide referrals to translators and interpreters. All fees for such services are Your responsibility.

Emergency Pet Housing and/or Pet Return: We will coordinate arrangements for temporary boarding or the return of a pet left unattended as a result of Your Injury or Illness. Any fees will be billed to Your credit card at the time of service.

Replacement of Lost or Stolen Travel Documents Assistance: We will provide assistance to You by arranging for the replacement of passports, visas, airline documents, birth certificates and other travel-related documents. You are responsible for all costs other than shipping. These expenses will be billed to Your credit card prior to shipping.

PROGRAM DEFINITIONS

The Following Definitions Apply:

"You" and "Your" means Insured, Spouse and Dependent(s).

"Spouse" means the Insured's Spouse (to include legally recognized domestic partner), unless they are legally separated.

"Dependent" means the Insured's unmarried children from birth through age 18; or through age 22 if enrolled as a full-time student in an accredited college, university, vocational or technical school; or whose support is required by a court decree, or adult child(ren) or grandchild(ren) with mental or physical disabilities who are solely dependent for maintenance and support. Children include natural children, stepchildren and legally adopted children. They must be primarily dependent on the Insured for support and maintenance and must live in a parent-child relationship with the Insured. If traveling on a trip without the Insured, Dependents are covered provided the trip does not exceed ninety (90) days.

"We," and "Our," means and/or refers to Worldwide Rescue & Security, Inc. and/or Our service provider.

"Hospitalized" means being admitted as an inpatient after Your initial visit in the emergency room.

"Illness" means a sudden and unexpected sickness that manifests itself during Your Policy Year and which requires Hospitalization.

"Injury" means an identifiable accidental injury caused by a sudden, unexpected, unusual, specific event that occurs during Your Policy Year and which requires Hospitalization.

“Permanent Primary Residence” means the locale of the address as shown on Your state driver’s license or state-issued identification card.

“Policy Year” means the one-year period of time that begins with Your policy effective date and for which premium is paid.

“Trip” means travel of at least 50 miles from Your Permanent Primary Residence during the Policy Year where Travel Arrangements have been reserved prior to departure on Your Trip.

“Travel Arrangements” means transportation, accommodations, and other specified services arranged for Your Trip.

The Travel Shield product consists of all benefits shown herein and benefits are not available for individual purchase.