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Truckers Occupational Accident Insurance Coverage

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SECTION I

GENERAL DEFINITIONS

Accident means a sudden, abrupt, discrete, and unexpected event resulting in physical injury, and that takes place without expectation and abruptly, rather than something which continues, progresses, or develops.

Administrator means an Administrator named in the Schedule of Benefits.

Authorized Passenger means a passenger: (1) who is listed as an Authorized Passenger in the Schedule of Benefits provided by the Certificateholder; (2) who is a minimum of 16 years of age; (3) who does not drive the vehicle, load or unload cargo, secure or unsecure cargo, fuel or participate in any other activity of the vehicle; and (4) for whom premium has been paid. In no event will the term "Authorized Passenger" include a hitchhiker.

Co-Owner means a person who has partial ownership of a vehicle which is being operated by an Owner- Operator for the purpose of performing Occupational services,

Combined Single Limit means, with respect to any one Insured Person, the total amount of benefits that are payable under this Policy for or in connection with Injury sustained as the result of any one Accident. When the Combined Single Limit has been reached, no further benefits shall be payable under this Policy, with respect to that Insured Person, for or in connection with Injury sustained as the result of that one Accident.

Contract Driver means a person who: (1) for the purpose of performing Occupational services, drives a vehicle owned or leased by an Owner-Operator; (2) is on file with the Company; (3) is not an employee of the Policyholder and (4) is not an employee of an Owner-Operator, unless it is not mandatory for workers' compensation coverage to be provided for such person as an employee of either the Policyholder or an Owner-Operator.

Covered Contract means a written lease as defined by Department of Transportation regulations. To be a "Covered Contract", such lease must meet all of the following conditions:

(1) it must be signed by both the Motor Carrier and the Owner-Operator;
(2) it must provide that the Owner-Operator is responsible for:
    (a) power unit maintenance;
    (b) power unit operating costs, including but not limited to:
        (i) fuel,
        (ii) repairs,
        (iii) physical damage, and
        (iv) all other operating expenses of the power unit;
(3) it must provide that the Owner-Operator is to be compensated on a basis other than one based solely on time expended in performing work;
(4) it must provide that the Owner-Operator, and not the Motor Carrier, shall have the responsibility for determining the time, means, and method of performing Occupational Services; and
(5) it must provide that the Owner-Operator is an independent contractor and not an employee of the Motor Carrier.

Covered Loss(es) means one or more of the losses or expenses described as such in Section IV of this Policy.

Dependent Child(ren) means the Insured Person's unmarried children (including natural children from the moment of birth, step- or foster-children, or adopted children, from the moment of placement in the home of the Insured Person) who are under age 19 (24 if attending an accredited institution of higher learning on a full-time] [basis) and primarily dependent on the Insured Person for support and maintenance at the time of the Insured Person's death caused by an Occupational Injury. It also includes any unmarried Dependent Child(ren) of the Insured Person who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured Person for support and maintenance at the time of the Insured Person's death caused by an Occupational Injury.

The Company may require proof of the Dependent Child(ren)'s incapacity and dependency within 60 days before the Dependent Child(ren) reach(es) the age limit specified above. The Company may request that satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency be submitted to the Company on an annual basis. If the requested proof is not furnished within 31 days of the request, such child(ren) shall no longer be considered Dependent Child(ren) as of the end of that 31 day period.

Dispatch means the time the Insured actually operates a truck, including all of the following:
(1) In route to pick up a load;
(2) Picking up a load;
(3) In route to deliver a load;
(4) Unloading a load;
(5) The waiting time for a load if the Insured is not at home.
Dispatch does not include time spent (a) during overnight stops, (b) on personal errands or personal side-trips, (c) for rest, entertainment or relaxation, or (d) in travel between the Insured's residence and a place at which the Insured performs Occupational services.

Functional Capacity Examination (FCE) means an examination performed by a physical therapy professional to evaluate and estimate physical limitations.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild).

Injury means physical Injury to an Insured Person caused by an Occupational Accident while coverage is in force under this Policy, which results directly and independently of all other causes in a Covered Loss. All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

Insured means a person who: (1) is a member of an eligible class as described in the Eligible Persons section of the Schedule of Benefits, and (2) has enrolled for coverage, and (3) has paid the required premium. However, an Insured does not include any person covered under this Policy solely as an Authorized Passenger.

Insured Person means an Insured or, if Authorized Passenger coverage is scheduled on the Schedule of Benefits, an Authorized Passenger.

Motor Carrier means a private or for-hire government-authorized legal entity engaged in the trucking business with whom the Owner-Operator has a Covered Contract. The Motor Carrier is identified on the Schedule of Benefits as the "Motor Carrier" or if an insurance trust has been established for the purpose of securing insurance "Participating Motor Carrier."

Occupational means, with respect to an activity, accident, incident, circumstance or condition involving an Insured, that the activity, accident, incident, circumstance or condition is proximately caused by the Insured's performing services within the course and scope of contractual obligations for the Motor Carrier, while under Dispatch or while operating under the Insured's Federal Highway Administration authority. With respect to an Authorized Passenger, the term Occupational means that the activity, Accident, incident, circumstance or condition occurs during and is proximately caused (a) while the Insured is performing Occupational services and (b) by and during the Authorized Passenger's riding as a passenger in or on (including getting in or out of, or on or off of) the vehicle. "Occupational" does not encompass any period of time during the course of travel between an Insured's residence and any place at which that Insured performs Occupational services.

Occupational Assessment means a determination of vocational capabilities. The determination process may include a review of medical records, Injury and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math, and vocational alternatives.

Occupational Cumulative Trauma means Injury to an Insured caused by the combined effect of repetitive physical Occupational activities extending over a period of time, where: (1) such condition is diagnosed by a Physician, (2) the Insured's last day of last performance of the activities causing the Injury occurred during the effective period of this policy, and (3) such activities resulted directly and independently of all other causes in a Covered Loss.

Occupational Disease means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the Insured's Occupational activities, where: (1) such condition is diagnosed by a Physician and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards, (2) exposure to such hazards is not an Accident but is caused or aggravated by the conditions under which the Insured performs Occupational services, (3) the Insured's last day of last exposure to the environmental or physical hazards causing such sickness occurs during the effective period of this policy, and (4) such exposure results directly and independently of all other causes in a Covered Loss.

Owner-Operator means a person who: (1) owns or leases a vehicle (from an entity other than the Policyholder) which he or she is operating for the purpose of performing Occupational services, (2) is an independent contractor as defined by law, and (3) is not an employee of the Policyholder. Owner-Operator includes a Co-Owner, but only if the Co-Owner otherwise meets the definition of Owner-Operator.
Physician means a practitioner of the healing arts, acting within the scope of his or her license, who is neither: (1) the Insured Person nor (2) an Immediate Family Member of the Insured Person nor (3) retained by the Motor Carrier.

Pre-Existing Condition means a health condition for which an Insured Person has sought or received medical advice or treatment at any time during the twelve months immediately preceding his or her effective date of coverage under this Policy.

Schedule means the Schedule shown in the Schedule of Benefits for this Policy, which is attached to and made a part of this Policy.

Spouse means the person to whom the Insured Person is legally married and with whom the Insured person co-habits in a continuous and open manner.

Trustee means the legal administrator or manager of the Great American Insurance Trust. The Trustee is the Policyholder on policies where an insurance trust has been established for the purpose of securing insurance.

SECTION II

EFFECTIVE PERIOD

Policy Effective, Expiration, and Termination Dates

Policy Effective Date. The effective period of this Policy begins on the Policy Effective Date shown on the Schedule of Benefits, at 12:01 A.M. Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Expiration Date. The expiration of this Policy is the Anniversary/Termination Date shown on the Schedule of Benefits at 12:01 A.M. Standard Time at the Policyholder's address unless the policy is renewed.

Policy Termination Date. The effective period of this Policy will end at 12:01 A.M. Standard Time at the Policyholder's address on the earliest of:

1. the Policy Anniversary/Termination Date shown on the Schedule of Benefits page, unless renewed before that date;
2. the premium due date, if we do not receive a required premium payment on or before that date;
3. the date specified in any written notice of the Company's intent to terminate this Policy, which will be at least thirty-one (31) days after the date the Company sends such notice to the Policyholder's and Certificateholder's last known mailing address; or
4. the date specified in any written notice of the Insured's intent to terminate this Policy, which must be at least thirty-one (31) days after the date the Policyholder sends such notice to the Company.

Termination of this policy before its anniversary date will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

Policy Non-Renewal

If the Company determines to not offer renewal terms for this policy, a notice to the Policyholder will be mailed no less than 30 days prior to the termination date listed on the Schedule of Benefits.

Owner-Operator's Effective and Termination Dates

Owner-Operator's Effective Date. An Owner-Operator's coverage under this Policy begins on the latest of:

1. the Policy Effective Date;
2. the date the person becomes a member of an eligible class of persons as described in the Eligible Persons section of the Schedule of Benefits;
3. if individual enrollment is required, the date written enrollment is received by the Motor Carrier, or
4. the date on which the first premium payment is received by the Company on or before its due date.

Owner-Operator's Termination Date. An Owner-Operator's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the effective date on which the Owner-Operator requests, in writing, that his or her coverage be terminated;
4. the effective date of any written notice of termination by the Company; or
5. the date the Owner-Operator ceases to be a member of any eligible class(es) of persons as described in the Description of Eligible Persons section of the Schedule of Benefits page.

Contract Driver's Effective and Termination Dates

Contract Driver's Effective Date. A Contract Driver's coverage under this Policy begins on the latest of:

1. the Policy Effective Date;
2. the date the person becomes a member of an eligible class of persons as described in the Eligible Persons section of the Schedule of Benefits;
3. if individual enrollment is required, the date written enrollment is received by the Motor Carrier; or
4. the date on which the first premium payment is received by the Company on or before its due date.

Contract Driver's Termination Date. A Contract Driver's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the effective date on which the Contract Driver requests, in writing, that his or her coverage be terminated;
4. the effective date of any written notice of termination by the Company;
5. the date the Contract Driver ceases to be a member of any eligible class(es) of persons as described in the Description of Eligible Persons section of the Schedule of Benefits; or
6. the date the Owner-Operator with respect to whom the Contract Driver is under contract ceases to be a member of an eligible class of persons as described in the Schedule of Benefits.

Authorized Passenger's Effective and Termination Dates

Authorized Passenger's Effective Date. An Authorized Passenger's coverage under this Policy begins on the latest of:

1. the Policy Effective Date;
2. the date the person becomes a member of an eligible class of persons as described in the Eligible Persons section of the Schedule of Benefits;
3. the date the Passenger Authorization Form is completed and received by the Motor Carrier; or
4. the date on which the first premium payment is received by the Company on or before its due date.

Authorized Passenger's Termination Date. An Authorized Passenger's coverage under this Policy ends on the earliest of:

1. the date this Policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date the Authorized Passenger ceases to be a member of an Eligible Class of persons as described in the Eligible Persons section of the Schedule of Benefits;
4. the date coverage ends for any reason with respect to the Owner-Operator or the Contract Driver with respect to whom he or she is an Authorized Passenger; or
5. the last day of the period for which the Authorized Passenger's coverage was elected and for which the premium has been received by the Company.

A change in an Insured Person's coverage under this Policy due to a change in his or her eligible class or benefit selection becomes effective on the later of: (1) the date the change in his or her eligible class or benefit selection is requested by the insured person and approved by the Company; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to Accidents that occur after the change becomes effective.

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination, if that Covered Loss results from an Accident that occurred while the Insured Person's coverage was in force under this Policy.

SECTION III

PREMIUM

Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premium section of the Schedule of Benefits. The Company may change the required premiums due on any Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least thirty-one [31] days' advance written notice. The Company may change the required premiums as a condition of any renewal of this Policy. The Company may also change the required premiums at any time when any change affecting premiums is made in this Policy.

Certificateholder's Premium. The Premium Rate for coverage under this Policy for each Insured Person is shown on the Schedule of Benefits and shall be payable as follows:

1. Insured Persons who are enrolled on or before the fifteenth day of a month shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage.
2. Insured Persons who are enrolled after the fifteenth day of a month shall pay the full monthly premium on the first day of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, Insured Persons shall pay the full monthly premium.

Waiver of Premium. Subject to this Policy's remaining in force, all premiums due under this Policy will be waived with respect to an Insured Person who is receiving either a Temporary Total Disability Benefit or Continuous Total Disability Benefit under this Policy. Premiums will be waived from the first premium due date on or after the date the disability begins. Premium payments must be resumed on the premium due date next following the date the Insured Person's Temporary Total Disability Benefit or Continuous Total Disability Benefit ceases. If premium payments are not resumed on that date, the Insured Person's coverage under this Policy shall end on that date.

SECTION IV

BENEFITS

For the purpose of computing the benefits to which an Insured Person is entitled under this policy, all Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury

Principal Sum
As applicable to each Insured Person, Principal Sum means the amount of insurance in force under this Policy on the date of the Accident, as described in the Schedule.

Deductible (Applies to Accident Medical Expense Benefits only)
The applicable Deductible Amounts shown in the Schedule apply per Covered Loss and to each Insured Person sustaining a particular type of Covered Loss. For Accidents causing more than one Covered Loss, each deductible amount is applied to the total benefits payable.

Accidental Death Benefit

If Injury to the Insured Person, directly caused by an Occupational Accident, results in the death of that Insured Person within the Incurral Period shown in the Schedule, the Company will pay a Survivor's Benefit, subject to the terms and conditions described in the Survivor's Benefit section below, and subject to any applicable Deductible Amount for the Accidental Covered Loss shown in the Schedule. The Incurral Period starts on the date of the accident that caused such Injury.

The Company shall have the right to develop a structured benefit distribution plan for the payment of any benefit(s) payable under this policy, whether through an annuity or otherwise. We do not need the consent or agreement of the Insured Person,

beneficiary, or any other person to develop and implement such a plan. Upon the purchase of an annuity, the obligation to make any and all future payments under this policy will be transferred to the company issuing the annuity. It is agreed that, in that event, the Insured Person or Designated Beneficiary will rely solely on that company to satisfy any and all further obligations for such benefits under this policy and no further demands or claims can or will be made against the Company for such benefits. If any person entitled to receive benefits is a minor or not competent to give a valid release, such benefits shall be paid to such person's legally appointed guardian or conservator.

Survivor's Benefit

If the Insured Person suffers accidental death such that an Accidental Death Benefit is payable under this Policy, the Company will pay a monthly Survivor's Benefit to the surviving Spouse, up to the Principal Sum shown in the Schedule. The Monthly Benefit Amount is determined by dividing the remainder of the Principal Sum after payment of any Lump Sum by the number of months shown in the Schedule of Benefits.

If the Insured Person is not survived by a Spouse, or if the Insured Person's Spouse dies or remarries, the Company will pay or continue to pay the Survivor's Benefit to the Insured Person's surviving Dependent Children, if any. If there is more than one surviving Dependent Child, the Survivor's Benefit will be distributed equally among the surviving Dependent Children. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date the Spouse dies or remarries, if there are no Dependent Children;
2. as to each Dependent Child, the date that Dependent Child dies or is no longer within the definition of Dependent Child as defined in Section I of this Policy; or
3. the date the Principal Sum has been paid.

If the Insured Person is not survived by a Spouse or Dependent Child, the Company will pay only the Accidental Death Benefit in accordance with the Payment of Claims provisions of this Policy.

Exposure and Disappearance

If, by reason of an Occupational Accident, an Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss which is otherwise covered under this Policy, the loss will be considered a Covered Loss under the terms of this Policy.

If the body of an Insured Person has not been found within one year after the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which that Insured Person was an occupant, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered Accidental Death within the meaning of this Policy. If, within 7 years, the Insured Person is later found living, all benefits paid must be immediately refunded to the Company.

Accidental Dismemberment Benefit

All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

Monthly Benefit: If Injury to the Insured Person, sustained as a result of an Occupational Accident, results in any one of the Losses specified below, within the Policy Period shown in the Schedule (as measured from the date of the Accident that caused such Injury), the Company will pay a monthly benefit equal to the Percentage of the Principal Sum shown below for that Loss, subject to any applicable Deductible Amount for the Accidental Dismemberment Covered Loss shown in the Schedule. Benefits will be payable in equal monthly payments up to the Maximum Benefit Period shown in the Schedule, subject to the Maximum Monthly Benefit Amount shown in the Schedule of Benefits. The amount of the monthly benefit is determined by multiplying the applicable Percentage of the Principal Sum by the Principal Sum, and then dividing that amount by the numbers of months in the Maximum Benefit Period. The payment of the monthly benefit ceases on the earlier of:

(1) the date the Insured Person dies; or
(2) the date the total amount of monthly benefits paid equals the Percentage of the Principal Sum shown below for that Loss.

For Loss of:	Percentage of the Principal Sum:
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Four Fingers of Same Hand	25%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand.	25%
All Toes of Same Foot	13%
One Thumb	10%
One Finger	2%
One Toe	1%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss' of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of an arm or leg means complete severance through or above the shoulder or hip joint. "Loss" of four fingers means complete severance through or above the metacarpophalangeal joint of all four digits. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Loss" of all toes means complete severance through or above the metatarsophalangeal joint of all five digits. "Loss" of one thumb means complete severance through or above the metacarpophalangeal joint of the digit. "Loss" of one finger means complete severance through or above the metacarpophalangeal joint of the digit. "Loss" of one toe means complete severance through or above the metatarsophalangeal joint of one digit.

If an Insured Person as a result of the same Accident sustains more than one Loss, only one amount, the largest, will be paid.

Severe Burn Benefit

All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury. The Accidental Dismemberment Benefit has been expanded to include Severe Burn as a covered loss.

If an Insured Person suffers an Injury that is a Severe Burn, the Company will pay a benefit as described below. The benefit payable is based on the Maximum Percentage of Accidental Dismemberment Principal Sum shown below and with respect to the specified body area shown below:

Specified Body Area	Maximum Percentage of Principal Sum
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint (Right)	22.5%
Hand and Forearm Below Elbow Joint (Left)	22.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Right)	13.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Left)	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints (Front)	36%
Torso Below Neck to Shoulder Joints and Hip Joints (Back)	36%
Thigh Below Hip Joint to Knee Joint (Right)	9%
Thigh Below Hip Joint to Knee Joint (Left)	9%
Foot and Lower Leg Below Knee Joint (Right)	27%
Foot and Lower Leg Below Knee Joint (Left)	27%

If only one of the Insured Person's Specified Body Areas is Severely Burned in an accident and 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is 100% of the Maximum Percentage of Principal Sum shown for that Specified Body Area. If only one of the Insured Person's Specified Body Areas is Severely Burned in an accident and less than 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is that same lesser percentage of the Maximum Percentage of Principal Sum shown above for that Specified Body Area.

(For example: The Maximum Percentage of Principal Sum shown for the "foot and lower leg below knee joint (right)" Specified Body Area is 27%. If 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is 100% of 27%, or 27%, of the Principal Sum. If 50% of that surface is Severely Burned, the benefit payable is 50% of 27%, or 13.5%, of the Principal Sum. If 1/3 of that surface is Severely Burned, the benefit payable is 1/3 of 27%, or 9%, of the Principal Sum.)

If more than one of the Insured Person's Specified Body Areas is Severely Burned as a result of the same accident, the benefit payable is the lesser of: (1) the sum of the benefit amounts calculated separately, according to the above rules, with respect to each such Specified Body Area; or (2) 100% of the Principal Sum.

The determination of whether or not a Specified Body Area is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Physician. The Company has the right, at its own expense, to have the determination verified by a Physician of the Company's choice.

Severe Burn/Severely Burned - means cosmetic disfigurement of the surface of a body area due to an Injury that is a full-thickness or third-degree burn as determined by a Physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

Paralysis Benefit

All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury. The Accidental Dismemberment Benefit has been expanded to include Paralysis as a covered loss.

Monthly Benefit: If Injury to the Insured Person results in any type of paralysis specified below, within the Policy Period shown in the Schedule (as measured from the date of the Accident that caused such Injury), the Company will pay a monthly benefit equal to the Percentage of the Accidental Dismemberment Principal Sum shown below for that type of paralysis, subject to any applicable Deductible Amount for the Paralysis Covered Loss shown in the Schedule. Benefits will be payable in equal monthly payments, up to the Maximum Benefit Period shown in the Schedule, subject to the Maximum Monthly Benefit Amount. The monthly benefit is determined by multiplying the applicable Percentage of the Principal Sum by the Principal Sum, and then dividing that amount by the number of months in the Maximum Benefit Period.

The payment of the monthly benefit ceases on the earliest of:

(1) the date the Insured Person is no longer paralyzed,
(2) the date the Insured Person dies, or
(3) the date the total amount of monthly benefits paid equals the Percentage of the Principal Sum shown below for that Type of Paralysis.

Type of Paralysis:	Percentage of the Principal Sum
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%

"Quadriplegia" means the complete and irreversible paralysis of both upper and both lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one limb. "Limb" means entire arm or entire leg. As used in this policy, neither quadriplegia, paraplegia, hemiplegia, uniplegia, nor paralysis includes paresis.

Paralysis benefits for more than one type of paralysis may not be combined. If an Insured Person sustains more than one type of paralysis as a result of the same Accident, the only paralysis benefit payable under this policy will be the largest single paralysis benefit that applies.

Temporary Total Disability Benefit

If Injury to the Insured Person results in Temporary Total Disability within the period between the date of Injury and the policy Anniversary/Termination date shown in the Schedule, and if the Insured Person is under age 70 on the day the Temporary Total Disability begins, the Company will pay the Temporary Total Disability Benefit specified below, subject to satisfaction of any applicable Waiting Period shown in the Schedule. The Waiting Period starts on the date of the Accident that caused such Injury. After the Waiting Period has been satisfied, the Temporary Total Disability Benefit shall be payable, retroactively from the date the disability began, provided the Insured Person remains Temporarily Totally Disabled.

The Temporary Total Disability Benefit with respect to each week of an Insured Person's Temporary Total Disability during a Single Period of Total Disability is equal to the lesser of:

1. 70% of the Insured Person's Average Weekly Earnings; or
2. the Maximum Weekly Benefit Amount shown in the Schedule.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date the Insured Person is no longer Temporarily Totally Disabled;
2. the date the Insured Person dies;
3. the date the Insured Person attains age 70; or
4. the date the Maximum Benefit Period shown in the Schedule has been reached.

The Temporary Total Disability Benefit with respect to less than a full Benefit Week of Temporary Total Disability equals 1/7th of the weekly benefit for each day of Temporary Total Disability.

As used above in this Temporary Total Disability Benefit section:

Average Weekly Earnings means the Insured Person's average weekly gross income from Occupational services as reported to the Internal Revenue Service as Adjusted Gross Income on the Insured Person's federal tax return for the tax year immediately preceding the year in which the Temporary Total Disability began.

Benefit Week means a 7-day period of time that begins on the first day of Temporary Total Disability after the Waiting Period shown in the Schedule for Temporary Total Disability and on the same day of each Week thereafter.

Maximum Benefit Period means, with respect to Temporary Total Disability, the maximum period for which benefits shall be payable for a Temporary Total Disability Covered Loss during a Single Period of Total Disability. The length of the Maximum Benefit Period for Temporary Total Disability is shown in the Schedule.

Single Period of Total Disability means all periods of Temporary Total Disability due to the same or related causes (whether or not this insurance has been interrupted) except any of the following which are considered separate periods of disability:

(1) successive periods of Temporary Total Disability, due to entirely different and unrelated causes, separated by at least one full day during which the Insured Person is not Temporarily Totally Disabled; and

(2) successive periods of Temporary Total Disability, due to the same or related causes, separated by at least 6 months during which the Insured Person is not Temporarily Totally Disabled.

Temporary Total Disability and Temporarily Totally Disabled refer to disability that:

(1) prevents an Insured Person from performing the duties of his or her regular, primary occupation; and

(2) requires and results in the Insured Person's receiving Continuous Care.

Continuous Care means medical monitoring and/or evaluation of the disabling condition by a Physician on a monthly or more frequent basis. The Company must receive proof of continuing Temporary Total Disability on at least a monthly basis.

Continuous Total Disability Benefit

If Injury to the Insured Person, resulting in Temporary Total Disability, subsequently results in Continuous Total Disability, the Company will pay the Continuous Total Disability Benefit specified below, provided:

1. benefits payable for a Temporary Total Disability Covered Loss ceased solely because the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, but the Insured Person remains disabled; and
2. the Insured Person is under age 70 on the day after the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached; and
3. the Insured Person has been granted a Social Security Disability Award for his or her disability; and
4. the Insured Person's disability is reasonably expected to continue without interruption until the Insured Person dies.

The Continuous Total Disability Benefit with respect to each month of an Insured Person's Continuous Total Disability is equal to four and three-tenths (4.3) times the weekly benefit for Temporary Total Disability, less the Insured Person's primary Social Security Disability Award.

The Continuous Total Disability Benefit with respect to less than a full Benefit Week of Continuous Total Disability equals 1/7th of the weekly Benefit for Temporary Total Disability for each day of Continuous Total Disability.

Benefits payable under the Temporary Total Disability Benefit before the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, will not be considered a continuous Total Disability Benefit.

The Continuous Total Disability Benefit shall cease on the earliest of the following dates:

1. the date the Insured Person is no longer Continuously Totally Disabled,
2. the date the Insured Person dies,
3. the date the Insured Person's Social Security Disability Award ceases,
4. the date the Insured Person attains age 70,
5. the date the Maximum Benefit Period shown in the Schedule for Continuous Total Disability has been reached.

As used in this Continuous Total Disability benefit section:

Benefit Week means a one-week period of time that begins on the day after the Maximum Benefit Period for Temporary Total Disability has been reached and on the same day of each week thereafter.

Maximum Benefit Period means, with respect to Continuous Total Disability, the maximum period for which benefits shall be payable for a Continuous Total Disability Covered Loss(es). If applicable, the length of the Maximum Benefit Period for Continuous Total Disability is shown in the Schedule.

Continuous Total Disability and Continuously Totally Disabled refer to disability that:

(1) prevents an Insured Person from performing the duties of all occupations for which he or she is otherwise qualified by reason of education, training or experience; and
(2) requires and results in the Insured Person's receiving Continuous Care.

Continuous Care means medical monitoring and/or evaluation of the disabling condition by a Physician on a monthly or more frequent basis. The Company must receive proof of continuing Continuous Total Disability at least on a quarterly basis.

Other terms used in this Continuous Total Disability benefit, but which refer to Temporary Total Disability and are defined in the Temporary Total Disability benefit section, are to be interpreted as defined in that section.

Accident Medical Expense Benefit

If an Insured Person suffers an Occupational Injury that, during the effective period of this policy shown in the Schedule, requires him or her to be treated by a Physician, the Company, will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Benefit Amount and Incurral Period shown in the Schedule per Insured Person for all Injuries caused by a single Accident, subject to any applicable Deductible Amount. The Incurral Period starts on the date of the accident that caused such Injury. The Deductible Amount for the Accident Medical Expense Benefit is the Deductible Amount shown in the Schedule, if any, which must be met separately for each Accident from the Usual and Customary Charges for Medically Necessary Covered Accident Medical Services incurred due to Injuries sustained by the Insured Person in that Accident.

As used in this Accident Medical Expense Benefit provision:

Ambulatory Medical Center means a licensed public establishment with an organized staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing surgical procedures. Such establishment must provide continuous Physician and registered nursing (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital, a Physician's office, or a clinic.

Covered Accident Medical Service(s) means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician, a Registered Nurse, LPNs, BSNs, nurse practitioners, PAs, or other kinds of licensed nursing personnel;
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy, Occupational therapy, and chiropractic care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule;
9. rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances; or
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription; or
12. The following specific Dental Services, required to treat a dental Injury as a result of an Occupational Accident which happens while covered:
    (1) Appliances and splints placed on or attached to sound natural teeth
    (2) Full or partial dentures.
    (3) Fixed bridgework if needed because of accidental injury to sound natural teeth
    (4) Prompt repair to sound natural teeth if needed because of accidental injury to those teeth.

Custodial Services means any of the following kinds of services which are provided to care for an Insured Person's physical well-being, but are not intended primarily as medical treatment for a specific Injury. Custodial Services include, but shall not be limited to, services:

(1) related to watching or protecting the Insured Person;
(2) related to performing or assisting the Insured Person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
(3) that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can also be used in the treatment of injury or for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Hospital means a facility that:

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

Incurral Period means, with respect to Accident Medical Expense, the maximum period for which benefits shall be payable for Covered Accident Medical Services for or in connection with a single Accident Medical Expense Covered Loss. The length of the Incurral Period for Accident Medical Expense is shown in the Schedule.

Medically Necessary means that a Covered Accident Medical Service: (1) is essential for diagnosis, treatment or care of the Occupational Injury for which it is prescribed or performed, (2) meets generally accepted standards of medical practice, and (3) is ordered by a Physician and performed either by a Physician or under his or her care, supervision or order.

Personal Comfort or Convenience Item(s) means those items that are not Medically Necessary for the care and treatment of the Insured Person's Occupational Injury. The term Personal Comfort or Convenience Item(s) includes, but is not limited to: (1) a private Hospital room, unless Medically Necessary; (2) television rental; and (3) Hospital telephone charges.

Sound Natural Teeth means natural teeth that either are unaltered or are fully restored to their normal function and are disease-free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (or, for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, one that does not exceed the Hospital's most common charge for semi- private room and board); and (3) does not include charges that would not have been made if no insurance existed.

In addition to the Exclusions in Section VI of this policy, Usual and Customary Charges for Covered Accident Medical Services do not include, and benefits are not payable with respect to, any expense for or resulting from:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing Durable Medical Equipment, unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
2. new or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. new eyeglasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Occupational Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;
4. new hearing aids or hearing examinations, unless Injury has caused impairment of hearing-, or repair or replacement of existing hearing aids, unless for the purpose of modifying the item because Occupational Injury has caused further impairment of hearing;
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident

Medical Expense Benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense Benefit in lieu of such rental expense);

6. Custodial Services; or
7. Personal Comfort or Convenience Items.

We will not pay for such items.

NON-OCCUPATIONAL COVERAGE

Non-Occupational Coverage. References in this Policy to an Injury or Accident, where applicable, are hereby deemed to include Non-Occupational Injury and Non-Occupational Accident, respectively. Benefits shall be payable for only those Covered Losses listed in the Schedule under Non-Occupational Accident Benefits, and shall be subject to the Non-Occupational Accident Benefit limitations shown therein.

Non-Occupational means, with respect to an activity, Accident, incident, circumstance or condition involving an Insured Person, that it is not proximately caused by the Insured Person's performing Occupational Services.

Non-Occupational Injury means physical Injury caused by a Non-Occupational Accident occurring while this policy is in force as to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a Covered Loss.

All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

SECTION V

LIMITS OF LIABILITY

Per-Insured Person Limit of Liability. The Per-Insured Person Limit of Liability (Combined Single Limit) stated in the Schedule will be the total limit of the Company's liability for any and all benefits payable under this Policy with respect to any one Insured Person arising out of any and all Injury sustained by such individual as the result of any one Accident.

Aggregate Limit of Liability. The Aggregate Limit of Liability stated in the Schedule will be the total limit of the Company's liability for all benefits payable under this Policy with respect to all Insured Persons arising out of Injury sustained by one or more Insured Person(s) as the result of any one Accident.

If the total of such benefits exceeds the Aggregate Limit of Liability, the Company shall not be liable to any Insured Person for a greater proportion of such Insured Person's benefits than said Aggregate Limit of Liability bears to the total benefits afforded all such Insured Persons under this Policy.

SECTION VI

EXCLUSIONS

This Policy does not cover any Injury, Accident, expense, or loss caused in whole or in part by, or resulting in whole or in part from, any of the following:

1. an Insured Person's suicide or any attempt at suicide; intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;
2. sickness, disease or infection of any kind, except bacterial infection due to a cut or wound, or botulism or ptomaine poisoning, caused directly by an Occupational Accident;
3. any Pre-Existing Condition, unless the Insured Person has been continuously covered under this Policy (or a substantially identical policy issued by the Company or another insurer, of which this policy is a renewal) for twelve consecutive months;
4. Occupational Cumulative Trauma, unless (and then only to the extent that) such coverage has been specifically added to this Policy by endorsement;
5. Occupational Disease, unless (and then only to the extent that) such coverage has been specifically added to this Policy by endorsement;
6. hernia of any kind, unless (and then only to the extent that) such coverage has been specifically added to this Policy by endorsement;
7. hemorrhoids of any kind, unless (and then only to the extent that) such coverage has been specifically added to this Policy by endorsement;
8. performing, learning to perform or instructing others to perform as a master or crew member of any vessel while covered under the Jones Act or the United States Longshoremen's and Harbor Workers' Compensation Act or any amendment of that Act, or any similar state or federal law;
9. declared or undeclared war, or any act of declared or undeclared war;
10. full-time active duty in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty;
11. any Injury for which the Insured Person is entitled to benefits pursuant to any workers' compensation law or other similar legislation;
12. employers' liability
13. the Insured Person's being under the influence of any drug or intoxicant, unless taken at the direction of his or her Physician; or
14. the Insured Person's commission of, or attempt to commit, a felony; or
15. travel or flight in or on (including getting in or out of, or on or off of) any type of aircraft, if the Insured Person is:
    a. riding as a passenger in an aircraft not designed and licensed for the transportation of passengers; or
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder; or
16. any strike, boycott or stop-work action, whether or not the Insured Person participated in such strike, boycott, or stop-work action.

SECTION VII

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be received by the Company within 20 days after an Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice must be given by or on behalf of the claimant to the Company at Great American Insurance Company, Trucking Division Claims, 49 E. 4th St. Suite 300 North; Cincinnati, OH 45202, 1-800-643-7882, with information sufficient to identify the Insured Person.

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

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

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. Upon receipt of due written proof of loss, payments for all other losses will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments required under this policy have been made, then any remaining amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

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

The Company may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. Such request must be made no later than the time proof of loss is filed. Any payment the Company makes in good faith fully discharges the Company's- liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under this Policy, other than for loss for which this Policy provides for periodic payments, will be paid within sixty (60) days after the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Commutation of Losses. It is agreed that, at the Company's option, at any time later than two years from the date of any Accident resulting in a claim under this Policy, the Company may advise the Insured Person of its desire to be released from liability with respect to any such claim. In that event, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and the payment by the Company of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim.

Sunset. No claim by any Insured Person or beneficiary will be considered valid or collectible under this Policy unless full details of such claim have been presented to the Company within two (2) years from the date of the Accident which gives rise to such claim.

SECTION VIII

GENERAL PROVISIONS

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

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

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

Beneficiary Designation and Change. The Insured Person's designated beneficiary(ies) is (are) the person(s) so named by the Insured Person and on signed record with the Policyholder and the Insurance Agency listed on the Schedule of Benefits. Designated beneficiaries are restricted to a class of beneficiaries as defined by the applicable workers' compensation laws, namely the Insured Person's Spouse and/or Dependent Child(ren). .

A legally competent Insured Person over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advance by the Company, the Policyholder and the Insurance Agency listed on the Schedule of Benefits with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, the Policyholder or Authorized Insurance Agent, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but will not apply to or prejudice the Company as respects any payment which may have been made prior to the Company's receipt of the request.

Physical Examination and Autopsy. The Company has the right, at its own expense, to examine the person of any Insured Person whose Injury is the basis of a claim, when and as often as may be reasonably required during the pendency of the claim. In the case of a disability claim, the Company also has the right to require the Insured Person, at the Company's expense, to submit to an Occupational Assessment and/or a Functional Capacity Examination. The Company may also require an autopsy of the remains of any Insured Person where it is not prohibited by law.

Legal Actions. No legal action for a claim can be brought against the Company until 60 days] after receipt of proof of loss. No legal action for a claim can be brought against the Company more than three years after the time for giving proof of loss.

Right to Examine Coverage. The coverage provided under this Policy may be terminated for any reason by the Insured Person within thirty (30) days after initial enrollment. Written notice of termination should be forwarded by mail or in person to the Company at its Home Office. Any premium paid will be refunded and the coverage will be treated as if it had never been issued.

Noncompliance With Policy Requirements. No express waiver by the Company of any requirement(s) of this Policy will constitute a continuing waiver of such requirement(s). Any failure by the Company to insist upon compliance with any Policy provision(s) will not operate as a waiver or amendment of that provision.

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

Clerical Error. Clerical error, whether by the Policyholder, the Certificateholder, the Insurance Agency listed on the Schedule of Benefits, or the Company in keeping records pertaining to this Policy, will not: (1) invalidate coverage otherwise validly in force; or (2) continue coverage otherwise validly terminated.

Data Required. The Policyholder and the Motor Carrier must maintain adequate records acceptable to the Company and provide any information required by the Company relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Audit. The Company will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder and the Motor Carrier that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Subrogation. To the extent the Company pays for losses incurred, the Company may assume the rights and remedies of the Insured Person relating to such loss. The Insured Person shall do nothing to prejudice such rights, and agrees to assist the Company in preserving such rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to the Company herein or which the Company may have by operation of law, when payments have been made by the Company with respect to a Covered Loss in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this Policy, the Company shall have the right to recover such excess payment from any one or more of the following: any person to whom such payments were made (e.g., medical providers, etc.), the Insured Person, any beneficiary, any insurance company, or any other organization(s) which received, or should have received, the payment.

Conditional Claim Payment. If an Insured Person suffers Covered Loss(es) as the result of Injuries for which, in the opinion of the Company, a third party may be liable, the Company will pay the amount of benefits otherwise payable under this Policy. However, if the Insured Person receives, collects, or recovers damages or other payment from the third party, the Insured Person agrees to refund to the Company the lesser of: (1) the amount actually paid by the Company for such Covered Loss(es); or (2) an amount equal to the sum actually received from the third party for such Covered Loss(es). If the Insured Person does not receive payment from the third party for such Covered Loss(es), the Company reserves the right to subrogate under the Subrogation clause of this Policy.

The above amount shall be paid to the Company at the time such third party's liability is determined and satisfied, whether such damages and/or liability has been determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

Offset. The Company will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from the Policyholder to the Company against any balance or balances, whether on account of losses or otherwise, due from the Company to the Policyholder.

Other Insurance. If the Insured Person incurs losses for which benefits are payable under this policy and any one or more similar policies issued by the Company or one of its affiliates, the coverage under this Policy shall be in excess of such other insurance, and will not contribute to such a loss with such other insurance. This condition does not apply to: (1) the Accident Medical Expense benefit described in Section IV of this Policy; or (2) other insurance which the Insured Person has procured to apply in excess of the coverage under this Policy.

Plan and Exposure Changes. The Motor Carrier must notify the Company of any of the Policyholder's subsidiaries or affiliated companies that are to be included as part of the Motor Carrier under this Policy. Such notice must be received by the Company within thirty (30) days of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the subsidiary, affiliate, or other entity will not be considered a part of the Motor Carrier, or of a covered affiliate or subsidiary, and no person related to the such subsidiary, affiliate, or other entity will be considered as an Insured Person of the Motor Carrier, or of a covered affiliate or subsidiary for purposes of this Policy, until the date such notice is provided. The Company has the right to adjust the premium for this Policy based on any change in exposure, whether as a result of such notice or otherwise.

Non-Duplication of Workers' Compensation Benefits. No benefits shall be payable under this Policy for any loss for which the Insured Person claims coverage under any workers' compensation, employers' liability, occupational disease or similar law. In the event a claim is made under any workers' compensation, employers liability, occupational disease or similar law arising out of the same or substantially same Accident or Injury, the Insured Person must immediately reimburse the Company for all benefits paid in conjunction with that Accident or Injury.

Excess Benefits. When an Insured Person has any Injury or loss to which both Accident Medical Expense coverage under this Policy and health care coverage under one or more other policies or plans applies, then the Accident Medical Expense benefit under this Policy shall apply only in excess of the benefits of the other policy or plan as described below, unless **both:** (1) the other policy or plan has coordination or excess benefits rules that require its benefits to be determined in excess of the benefits of this Policy; **and** (2) this Policy has covered the Insured Person longer than the other policy or plan has.

When the Accident Medical Expense benefit under this Policy is excess, such benefits for any Allowable Expenses will be reduced when the sum of:

1. the amount of the Accident Medical Expense Benefit Deductible, if any, that would be applied to those Allowable Expenses under this Policy in the absence of this provision, **plus**
2. the benefits that would be payable for those Allowable Expenses under this Policy in the absence Of this provision, **plus**
3. the benefits that would be payable for those Allowable Expenses under the other policy or plan in the absence of a coordination of benefits or excess benefits provision, exceeds the amount of those Allowable Expenses. In that case, first this Policy's Accident Medical Expense benefits, and next (if necessary) the applied amount of this Policy's deductible, if any, will be reduced so that this Policy's benefits (net of any applied deductible amount) and the other policy's or plan's benefits do not total more than the amount of those Allowable Expenses.

Right to Receive and Release Needed Information. The Company has the right to decide in its sole judgment what facts it needs to administer this Policy. It may get needed facts from, or give them to, any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to determine coverage under this Policy or determine the correct payment of a claim.

Facility of Payment and Right of Recovery. If a payment made under another plan includes an amount that should have been paid under this policy, the Company may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy and the Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Company is more than it should have paid under this policy, it may recover the excess from any person(s) to or for whom it has over-paid, including insurance companies or other organizations.

Allowable Expense - means the usual and customary charge for a medically necessary service or item of expense for health care when the item of expense is covered at least in part by this Policy and is also covered at least in part by one or more other policies or plans covering the Insured Person. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid, as if its reasonable cash value had been charged as the cost for the service and such expense would have been covered at least in part by the Policy.

As used above in this Section, **plan** includes any of the following group, group-type (such as, but not limited to, franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies, (2) subscriber contracts, (3) uninsured arrangements, (4) labor- management trustee, union welfare, employer organization, or employee benefit organization plans, (5) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans, (6) medical benefits coverage in automobile 'no-fault' and traditional automobile "fault" type contracts, and (7) coverage under any governmental plan (including provincial plans) or coverage required or provided by law; but **plan** does not include: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) this Policy, or (c) a plan or law that, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan.