UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way, Eatontown, New Jersey 07724

EXCESS LOSS INSURANCE POLICY

POLICYHOLDER:	[Employer's Name]
POLICY NUMBER:	[9999999 99999999999]
POLICY EFFECTIVE DATE:	[January 1, 2006]
STATE OF DELIVERY:	[State]
POLICY TERM:	[December 31, 2006]

The Insurance Company agrees to pay benefits to the Policyholder if the required premium is paid when due. This Policy describes the terms and conditions of coverage. The Policy is issued in the State of Delivery and shall be governed by its laws.

The Policy goes into effect on the Policy Effective Date, 12:01 AM at the Policyholder's address. It will automatically terminate at the end of the Policy Term unless it is renewed in writing.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

NOTICE

The Policy provides benefits when the Policyholder's health plan has incurred expenses beyond the individual and/or aggregate (whichever is applicable) deductibles outlined in the Policy. Since the Policy insures the Policyholder and not the individuals covered by the Policyholder's health plan, the Policy neither adds to nor subtracts from the terms of the underlying Plan. Additionally, the Policy does not in any way, affect the Policyholder's responsibility to comply with the employment laws such as the Americans With Disabilities Act, the Age Discrimination in Employment Act, Title VII of the 1964 Civil Rights Act, and any applicable state laws.

Signed for **the United States Fire Insurance Company By:**

Joseph F. Braunstein, Jr.
President

Valerie J. Gasparik
Secretary

SAMPLE

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SCHEDULE OF BENEFITS

SCHEDULE EFFECTIVE DATE: [January 1, 2006]

COVERAGE PERIOD: [January 1, 2006-December 31, 2006]

[This Policy covers expenses incurred and paid by the Policyholder during the Policy Year.]

[This Policy covers expenses incurred during the Policy Year and paid by the Policyholder during the Policy Year [or within [12] months after it ends.]

[This Policy covers expenses paid by the Policyholder during the Policy Year.]

[This Policy covers expenses incurred by the Policyholder during the Policy Year or the [12] months prior to the Policy Effective Date and Paid during the Policy Year.]

[This Policy covers expenses incurred by the Policyholder during the Policy Year or the [12] months prior to the Policy Effective Date and Paid during the Policy Year or within [12 months] after it ends.]

[STOP LOSS BENEFITS:

Monthly Calculated Deductible Factor (MCD)

Employee Only:	[$100.00]
Employee with Dependents:	[$200.00]
Composite Factor:	[Not Applicable]

Scheduled Percentage for Aggregate Loss: [100%]

Minimum Aggregate Deductible: [$100,000]

Maximum Benefit for Aggregate Losses

Per Policy Year:	[$1,000,000]
Per Covered Person:	[$10,000]

Aggregate Advancement Loan Option (Monthly Aggregate Advance): [Yes]

Scheduled Percentage for Specific Loss: [100%]

Specific Deductible: [$10,000]

Maximum Benefit for Specific Losses: [$990,000]

Cash Loss Limit (Advanced Payment Benefit): [Yes]]

SAMPLE

[SPECIFIC ORGAN TRANSPLANT COVERAGE

Specific Organ Transplant Procedures

Maximum Benefit Period for Specified Organ Transplants:	[12 months]
Lifetime Maximum Specific Organ Transplant Benefit:	[$xxx]
Maximum Donor Organ Benefit:	[$xxx]]

[INITIAL PREMIUM RATES

Aggregate Stop Loss Premium	[$5.00]
Aggregate Advancement Loan Option	
(Monthly Aggregate Advance)	[$1.50]
Specific Stop Loss Premium	
Employee Only:	[$50.00]
Employee with dependents:	[$100.00]
Composite premium:	[Not Applicable]
Cash Loss Limit (Advanced Payment Benefit):	[$1.00]
Specific Organ Transplant Premium:	[$xxx]]

PREMIUM DUE DATE: [Monthly premiums are due on the 1st day of each month during the Policy Term.]

SAMPLE

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms are capitalized throughout this document. The definition of any word, if not defined in the provision where it is used, may be found either in this section or in the Schedule of Benefits.

[Active Service
An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires an Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved leave of absence (except absence due to sickness or injury) during which Plan coverage is in effect for that employee.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

A retiree, a Covered Person covered under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA), or an Employee's eligible dependents are in Active Service if they are not confined in a hospital, a facility that treats one or more special ailments, a skilled nursing facility, or are otherwise able to engage in all the normal activities of a person in good health of the same age and sex.]

[Aggregate Claim Payments
Aggregate Claim Payments are all of the claims paid by the Policyholder for Covered Persons as required by the Plan within the Coverage Period shown in the Schedule of Benefits. The term does not include any amount payable under the Specific Excess Loss Insurance provision or any other excess loss coverage.]

[Aggregate Deductible
The term means the sum of the Monthly Calculated Deductible for each month in the Policy Year, or the Minimum Aggregate Deductible shown in the Schedule of Benefits, if greater. This amount must be satisfied before any benefits are payable under the Aggregate Loss provision.

The Minimum Aggregate Deductible shown in the Schedule of Benefits shall be determined based on the enrollment provided at the time of quote or the initial enrollment on the effective date, whichever is greater.

The Aggregate Deductible must be met before there will be reimbursement. This applies even if there is an early termination.]

Covered Person
A Covered Person is an eligible employee, as defined by the Employer's Plan, who is covered under the Plan. [The term includes a covered employee's eligible dependents if they are covered under the Plan.]

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy.

Incurred Claims
Expenses are incurred on the date the service, treatment, supply or facility is provided to a Covered Person. Expenses do not include any amounts that are reimbursable by any other source or deductibles, coinsurance amounts or any other amounts not reimbursed by the Plan.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

SAMPLE

[Monthly Calculated Deductible(MCD)
The Monthly Calculated Deductible is either:
a) the sum of the Employee Only MCD Factor times the number of covered employees without dependents and the Employee with Dependents MCD Factor times the number of employees with enrolled dependents; or
b) the Composite MCD Factor times the number of Covered Employees.
MCD Factors are shown in the Schedule of Benefits.]

[Paid Claims
A claim is paid as of the date the payment instrument is issued. If there are insufficient funds in the Employer's account to cover the amounts of all the outstanding drafts or checks, it is paid on the date funds are available to honor the payments. The term does not include a claim payment made in error. The Policyholder will repay the Insurance Company for any benefit paid for a claim payment that is later recovered.]

[Plan
The Plan is the Employee Benefit Plan, sponsored by the Employer, providing a program of health and welfare benefits to Covered Persons. Any change in the Plan made after the Policy Effective Date must be approved in writing by the Insurance Company for coverage under this Policy to be effective. If approval is not received, the Insurance Company will continue to pay benefits at the lesser of:
a) the amount payable if the Plan was not changed; or
b) the amount payable under the new Plan.

The Insurance Company is not responsible for compliance of the Employer's Plan with any applicable laws. Any claim that results from the Plan's noncompliance will not be used to determine the benefits payable under the Policy.

The Policyholder warrants the Plan is not part of a Multiple Employer Welfare Arrangement, as defined in Section 3(40) of ERISA or maintained pursuant to a collective bargaining agreement with two or more unaffiliated employers. The only persons covered under the Plan are employees of the Employer, former employees of the Employer, or eligible dependents of an employee or former employee.]

Policy Year
A Policy Year is [12 consecutive months] starting with the Policy Effective Date or the effective date of any rider that extends the Policy Term. It will end on the last day of the Policy Term or the termination date of the Policy, if earlier.

Schedule of Benefits
The Schedule of Benefits states the coverage period, initial premium rates, deductibles, maximum benefits and other specific terms of coverage.

[Specific Claim Payment
This term means a payment made for a Covered Person under the terms of the Plan for an expense incurred within the Coverage Period shown in the Schedule of Benefits.]

ELIGIBILITY FOR INSURANCE

[Claim payments incurred on behalf of each employee and his or her eligible dependents covered under the Employer's Plan are eligible for coverage on the Policy Effective Date.]

EFFECTIVE DATE OF INSURANCE

SAMPLE

EFFECTIVE DATE - An employee who is in Active Service (and such employee's dependent's who are considered in Active Service) and who have coverage under the Plan will be covered under this Policy if added within 31-days after becoming eligible for Plan coverage. The effective date of coverage under this Policy is the Policy Effective Date, or the date Plan coverage is effective, whichever is later.

DEFERRED EFFECTIVE DATE – An employee who is not in Active Service during the 31-day period after becoming eligible for Plan coverage, will be covered under this Policy effective on the date of returning to Active Service. The effective date of coverage for such employee's dependents will be the day following the date of discharge from a hospital, a facility that treats one or more special ailments, a skilled nursing facility, and are otherwise able to engage in all the normal activities of a person in good health of the same age and sex.

LATE ENROLLEE EFFECTIVE DATE – For employee's and their dependents who were eligible for Plan coverage, but who did not enroll during the 31-day eligibility period, coverage under this Policy will take effect on the same day such person(s) are covered under the Plan, provided such persons are in Active Service on that date.

Any amount of Plan benefits paid by the Policyholder for a Late Enrollee, or for a person not considered in Active Service and who is subject to a Deferred Effective Date, will be disregarded for reimbursement under this Policy

TERMINATION OF INSURANCE

The Policy will end on the earliest of the dates below:

1. The date the Policy Term ends, if the Policy is not renewed. If the Policy terminates prior to the end of the Policy Term no further benefits are payable under the Policy.
2. The date the Plan is terminated.
[3. The date required premiums are not paid when due.
4. The date the Policyholder fails to fund benefits payable under the Plan provided 10 days written notice is given to the Policyholder.
5. The date agreed upon by both the Policyholder and the Insurance Company.
6. The date the Policyholder fails to give notice of a Plan change or a change in claims administrator.

DESCRIPTION OF BENEFITS

[SPECIFIC LOSS INSURANCE

The Insurance Company will pay the Scheduled Percentage of the excess of all the Specific Claim Payments for any Covered Person minus the Specific Deductible up to the Maximum Benefit for Specific Losses.]

[AGGREGATE LOSS INSURANCE

The Insurance Company will pay the Scheduled Percentage of the excess of the Aggregate Claim Payment minus the Aggregate Deductible up to the Maximum Benefit for Aggregate Losses.

The Aggregate Deductible is applied at the end of each Policy Year. If the Policy is terminated before the end of the Policy Year, the Aggregate Deductible must be satisfied in full before any benefits are payable. Any Specific Loss Insurance Benefits payable under the Policy may not be used to determine any benefits payable under this provision.

SAMPLE

The Scheduled Percentage and the Maximum Benefit are shown in the Schedule of Benefits. The Insurance Company will pay benefits as soon as reasonably possible after a request for payment is made.]

[ADVANCED SPECIFIC PAYMENT BENEFIT

The Company will pay an Advanced Specific Payment Benefit to the Policyholder for any Incurred Claims payable under the terms and conditions of the Policy. The following conditions must be met for this benefit to be payable:

1. The claim must be incurred by the Policyholder for services otherwise payable under the Policy.
2. The Policyholder must make a written request for an Advanced Specific Payment Benefit.
3. The Policyholder must pay the provider(s) of service an amount equal to the Specific Deductible applicable to the Covered Person for which the claim is incurred, plus [$2,500.00] for the initial claim. The total of each subsequent submission/request must be no less than [$5,000.00].
4. All premiums due under the Policy must be paid currently to the end of the month for the same month the Advanced Specific Payment was requested.

The Advanced Specific Payment Benefit will not be payable for any claims eligible for payment during the 31-days preceding the date of termination of the Policy.

The Advanced Specific Payment Benefit will be payable to the Policyholder in an amount equal to the remaining unpaid balance of the claim for which the Policyholder is liable, and for which benefits are payable under the Policy, subject to the Maximum Benefit for Specific Losses shown in the Schedule of Benefits.]

[SPECIFIC ORGAN TRANSPLANT COVERAGE

If the plan covers expenses incurred for organ transplants, the Insurance Company will cover the Specific Claim Payments for Specified organ Transplants. Benefits will not be paid for the following:

- Expenses incurred in obtaining, storing or transporting a donor organ;
- Any organ transplant using animal, mechanical or artificial organs;
- Expenses that exceed the Specific or Aggregate Maximum Benefit shown in the Schedule of Benefits.]

[SPECIFIC ORGAN TRANSPLANT COVERAGE

If the Plan covers expenses incurred for organ transplants, the Insurance Company will cover the Specific Claim Payments for Specified Organ Transplants. Expenses must be incurred within the Maximum Benefit Period for Specified Organ Transplants. Specific Organ Transplants and the Lifetime Maximum Specified Organ Transplant Benefit are shown in the Schedule of Benefits.

Any expenses used to satisfy the Specific Deductible or Specified Organ Transplant Deductible may not be used to satisfy the Aggregate Deductible. If there is no specific Deductible, expenses under this Specific Organ Transplant coverage may not be used to satisfy the Aggregate Deductible.

Donor Benefit

If the plan covers donor expenses incurred for organ transplants, the Insurance Company will pay a Donor Benefit for expenses incurred as a result of the surgical removal, storage or transportation of a donor organ for a Specific Organ Transplant.

The Insurance Company will not pay benefits for the following:

1. expenses incurred before the effective date of this Specified Organ Transplant Coverage;

SAMPLE

2. expenses for a condition for which a Covered Person received medical treatment, care or services within 12 months before his or her effective date of coverage under the Policy unless 12 consecutive months pass when no expenses are incurred for the condition;
3. any person who is Totally Disabled on the effective date of this Specified Organ Transplant Coverage until he or she is no longer Totally Disabled;
4. any procedure unless a Physician certifies the Covered Person's condition is life threatening, all conventional forms of treatment have been tried without success and the procedure is the only medically justified means of preserving the Covered Person's life;
5. any procedure if there is no second opinion agreeing with the need for the procedure offered by a Physician not associated with the Physician who originally recommended the surgery or the Physician who actually performs the surgery.

"Physician" means a licensed doctor practicing within the scope of his or her license. He or she must be rendering care and treatment to a Covered Person that is appropriate for the condition and locality. The term does not include a Covered Person or a Covered Person's spouse, parent, child or sibling (whether the relationship derives from blood or marriage) or a person living in the Covered Person's household.

"Totally Disabled" means an employee is unable to do all the substantial and material duties of his regular occupation. For dependents, it means the person is unable to do the normal activities of a person of like age and sex in good health.]

EXCLUSIONS AND LIMITATIONS

The Insurance Company will not pay benefits for any of the following:

[1. Claim payments for services, treatment, medicine or drugs related to any of the following circumstances:
  - self-inflicted injury or illness
  - declared or undeclared war or act of war
  - felony, riot or civil disobedience
  - nuclear reaction or the release of nuclear energy. (This exclusion will not apply if the loss is sustained within 90 days of the initial incident. To be covered under the Policy, the loss must be caused by fire, heat, explosion or other physical trauma that is a result of the release of nuclear energy and the Covered Person must be within a 25-mile radius of the release site at the time of the release or within 24 hours of the start of the release.)
  - Pre-existing conditions, as defined by the Plan, unless and until the medical treatment, services, or supplies for such condition(s) are covered under the Plan.
  - custodial care
  - sex reassignment

2. Any claim payment for expenses incurred in any of the following circumstances:
  - while an Employee is serving on full-time active duty in any armed forces
  - in excess of the charges the Insurance Company determines are reasonable and customary for the locality where the service is provided
  - for experimental drugs or any procedure held to be experimental or investigatory by the Insurance Company at the time the procedure is done
  - for an organ transplant or implant of non-human, artificial or mechanical organs
3. Claim payments not administered or paid according to the Plan, or for which there is no documented proof of loss, unless the payment was authorized in writing by the Insurance Company.
4. Any claim payment, or portion of a claim payment for any of the following expenses:
  - legal expenses, fines, penalties, damages, judgements or other penalties imposed by law
  - expenses covered by any workers compensation act or other law covering occupational injuries or disease
  - expenses related to any occupation or employment for wage or profit

SAMPLE

- expenses covered by any other medical plan or insurance including amounts recoverable under any coordination of benefits provision

5. Any claim payment for expenses resulting from [dental],[vision],[hearing care] or [prescription drug card] programs.
6. Any claim payment for services or treatment that are not Medically Necessary or rendered by a provider of Appropriate Care acting within the scope of his or her license. ("Medically Necessary" means the service, care or treatment is prescribed by a physician as Appropriate Care and is not solely for the convenience of the Covered Person or the provider of service. "Appropriate Care" means a provider is rendering services, care or treatment to a Covered Person that are consistent with generally-accepted medical standards for the condition and locality in which it is given and is required treatment for the Covered Person's injury or illness.)
7. Any claim payments for cosmetic services, unless performed as soon as medically feasible and necessary for any of the following conditions:
   - an illness or injury that occurs while covered under the Plan
   - reconstruction that is applicable to, or follows surgery resulting from an injury or illness. This exclusion does not apply to breast reconstructive surgery on a breast(s) for which a mastectomy has been performed, nor to reconstruction of the other breast to produce a symmetrical appearance.
   - the correction of a functional defect
   - the correction of a congenital defect that results in a functional defect of a covered child born while the employee is covered by the Plan.
8. Mental or Nervous illness [is not covered] [will be reimbursed on the same basis as any other illness] [is limited to xx days during the term of coverage]].
9. Any claim processed by the Claims Administrator: (a) outside of the order in which it was received by the Claims Administrator; or (b) outside of the usual and customary cycle of the Claims Administrator for processing claims will not be considered for reimbursement unless prior approval was given to the Claims Administrator by the Insurance Company to process the claim outside of the order in which it was received or outside of the usual and customary cycle of the Claims Administrator for processing claims. All claims will be processed by the Claims Administrator in the order in which they are received by the Claims Administrator and processed in the usual and customary cycle of the Claims Administrator for processing claims.]

CLAIM PROVISIONS

[Claims Administrator Changes

The Policyholder must notify the Insurance Company in writing of any change in claims administrator before the change is made. The Insurance Company reserves the right to approve a change in the claims administrator. If approval is not received, the Policy may be terminated.]

[Notice of Claim

Written notice of claim for a Specific Claim payment in excess of 50% of the Specific Deductible must be given to the Insurance Company within [60 days] after a covered loss occurs or begins. If written notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. Written notice can be given to the Insurance Company at its home office in Irving, Texas, or to its agent. Written notice should include the Policyholder's name and Policy Number, the name of the Covered Person, the date of the accident or the date the illness first manifested itself, the nature of the injury or illness and the estimated cost of the claim.

Benefits will not be paid for any claim not paid by the Policyholder within 60 days from the date adequate proof of loss is received unless the claim is reasonably in dispute. In this case, the Policyholder must give the Insurance Company written notice of a disputed claim within [60 days] of the receipt of adequate proof of loss. The Insurance Company may, at its discretion, extend the time period during which the claim may be paid and covered under the Policy.]

[Proof of Loss

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Written proof of loss must be given to the Insurance Company within 90 days after the date the Specific or Aggregate Deductible is satisfied. A claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. If written proof of loss is not given in that time, the Specific Claim Payment will be excluded from coverage under the Policy.]

[Policyholder Cooperation Provision
The Policyholder is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Failure of a Policyholder to cooperate with the Insurance Company in the administration of the Policy may result in its termination. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]

[Payment of Claims
Benefits will be paid to the Policyholder as soon as reasonably possible after a request for reimbursement is made].[However, request for reimbursements totaling less than $1,000 will be honored at the earlier of the end of the Policy or contract Year or when such requests, when combined with subsequent requests, exceeds $1,000 per Individual Claim.]

[Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss must be furnished.]

[Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Policy is delivered, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.]

[Subrogation
Any rights of the Policyholder to make a lawful claim against another party for compensation, damages or other payment for a claim payment are transferred to the Insurance Company, but only to the extent of benefits paid under the Policy. The Policyholder must complete any documents the Insurance Company may reasonably require to pursue its rights. If payment from another party is received, the Policyholder must first reimburse the Insurance Company for any benefits paid under the Policy, but not more than the amount paid by the other party.]

[Recovery of Overpayment
If benefits are overpaid, the Insurance Company has the right to recover the amount overpaid by the following methods:

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under the Policy.

ADMINISTRATIVE PROVISIONS

Premiums
[The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect. Initial Premium Rates are shown in the Schedule of Benefits.]

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least [31 days] advance written notice. No change in rates or factors will be made during the Policy Term. However, the Insurance Company reserves the right to change the rates at any time if any of the following events take place:

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1. The terms of the Policy or Plan change;
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy or Plan;
3. There is a change in the factors bearing on the risk assumed;
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's or the Plan's benefit obligation;
[5. The date an increase or decrease in the number of Covered Persons exceeds [10%] in any one month or [25%] over [3 consecutive months];]
[6. At any time after the first Policy Year if the average monthly Paid Claims for the last [2 months] of the previous Policy Year varies by more than [25%] for first year renewals involving [100 or less] Covered Persons as of the renewal date, or more than [10%] in any other case from the average monthly Paid Claims for the prior [10 months].]

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is covered under the Plan, the amount of benefits payable under the Plan and any other information needed to administer the Policy.

Payment of Premium
The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

[Notice of Cancellation

The Policyholder or the Insurance Company may cancel the Policy as of any Premium Due Date by giving [31 days] advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period Section.]

[Policy Grace Period
A Policy Grace Period of [31 days] will be granted for the payment of the required premiums under the Policy. The Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day for which premiums are paid. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the Policy was in force.]

GENERAL PROVISIONS

[Scope of Coverage
This Policy is an agreement solely between the Policyholder and the Insurance Company. It does not create any legal right or relationship between the Insurance Company and any Covered Person, provider of medical services or beneficiary under the Plan. The Insurance Company has no responsibility or obligation under the Policy to pay any person or provider of professional or medical services for any benefits payable under the terms of the Plan. Nor does the Insurance Company have any fiduciary responsibility under the Policy or the Plan.

The Insurance Company is not liable for any costs the Policyholder incurs because of a claim contested under the Plan or any extracontractual, compensatory, or punitive damages assessed against the Policyholder. The Policyholder agrees to indemnify and hold the Insurance Company harmless from any damages assessed against them.

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Entire Contract
The entire contract will be made up of the Policy and the application of the Policyholder, a copy of which is attached to the Policy.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of, and does not affect, any requirements for coverage under any Workers' Compensation Insurance.

Conformity with State Statutes
Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

Subcontracting
The rights and obligations of the Insurance Company under the Policy may be performed wholly, or in part, through an authorized representative, subsidiary, affiliate or parent of the Insurance Company. Any subcontracting agreement made by the Insurance Company will not increase or diminish the rights or obligations of the Policyholder or the Insurance Company.

Clerical Error
Coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premiums will be adjusted fairly.]

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