

Emergency Group Accident Protection



Available For

**Volunteer Fire Companies, Relief Squads, Paid-On-Call Members,
Ambulance Corps, Auxiliary Groups, Junior Firefighters,
Fire Cadet Programs, Rescue Companies**



Coverages are underwritten by
StarNet Insurance Company,
a Berkley Company, A+ rated by A.M.
Best, Financial Size Category XV,
Acadia Insurance Company in CT and
Great Divide Insurance Company in MA.

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When the alarm sounds, you have a job to do—you don't worry about the dangers associated with responding to a emergency situation and the possibility of injury or death. Firefighting and rescue work involves saving lives and limiting the property damage to those in and around your community. Because it's a risky business, injuries and sickness related to duty occur far to often and the possibility of disability exists with every response.

Placing oneself in harms way for the community is admirable. But injuries can place an enormous financial burden on loved ones, spouses and/or children. Many families have little or no medical insurance, and those who do have coverage may be required to meet large deductibles before their insurance pays any benefits. Don't be among the unfortunate who find out much too late that their insurance benefits, especially for this line of work, are inadequate or nonexistent.

It can happen to anyone...

That's why the Berkley Companies have specially developed the comprehensive Accident plan to cover the inherent risk associated with today's fire and rescue work. An array of optional benefits are available to be selected as needed by the Policyholder.

Eligible Covered Persons

- Officially designated volunteer members.
- Regular full time employees, who receive a salary for his or her duties
- Bystanders especially authorized by your officials to assist in an emergency situation
- Officially designated members of your Junior Fire or Fire Cadet Programs
- Officially designated members of your Ladies Auxiliary Group

Coverage is provided for:

- Taking part in or traveling directly to or from emergency duties
- At drills and parade duties, tests or trials of equipment
- Taking part in or attending as a volunteer member of any other approved and supervised activity
- Taking part in any organized, approved and supervised sports activity

Accidental Death & Dismemberment Benefit

Provides for payments of benefits in accordance with the following table if the Covered Person suffers an injury in a Covered Accident. If multiple losses occur, only one Benefit, the largest, will be paid for all losses due to the same Covered Accident.

Schedule of Covered Losses/Injury

<i>Loss of:</i>	<i>Benefit: (Percentage of Principal Sum)</i>
Life	100%
Brain Death	100%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Uniplegia	25%
Thumb & Index Finger of the Same Hand	25%
Four fingers of the Same Hand	25%

"Member" means Loss of Hand or Foot, Loss of Arm or Leg, Loss of Sight, Loss of Speech and Loss of Hearing. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of Arm or Leg" means complete Severance

through or above the elbow or knee joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, although the heart is still beating.

"Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.

"Paraplegia" means total Paralysis of both lower limbs or both upper limbs.

"Quadriplegia" means total Paralysis of both upper and lower limbs.

"Uniplegia" means total Paralysis of one lower limb or one upper limb.

Continuation of Other Medical and/or Dental Insurance Expense Benefit

We will pay this benefit if a surviving Spouse or a surviving Dependent Child elects to continue other group medical and/or dental insurance provided by the Policyholder of a Covered Person who died, subject to all of the following conditions:

- 1) the Covered Person's death results directly and independently of all other causes from a Covered Accident;
- 2) the Covered Person is survived by a Spouse or Dependent Child who are Covered under this Policy on the date the Covered Person dies;
- 3) the surviving Spouse or Dependent Child is also Covered under a medical and/or dental plan at the time the Covered Person dies; and
- 4) the surviving Spouse or Dependent Child notifies Us of his or her election, within 60 days of the Covered Person's death, to continue his or her existing coverage under group insurance plans sponsored by the Policyholder, as permitted by state or federal continuation law.

This benefit, payable annually, equals the premiums required to continue the medical and/or dental insurance described herein, as long as the total amount of this benefit does not exceed the Maximum Benefit. The benefit will be paid at the end of each year during which medical and/or dental insurance is continued, if We receive a request for reimbursement and proof of the premiums paid during that year. Benefit payments will continue to the earliest of the following dates:

- 1) the date a surviving spouse or Dependent Child is no longer eligible to continue medical and/or dental insurance coverage;
- 2) the date benefit payments equal the Maximum Benefit;
- 3) the end of the Maximum Benefit Period.

Coma Benefit

If a Covered Person suffers an Injury caused by an Accident which results in such person being in a Coma within 90 days of the Covered Accident and if the Coma continues for at least 30 consecutive days, We will pay a monthly benefit equal to 5% of the Covered Person's Amount of Insurance.

Felonious Assault and Violent Crime Benefit

If a Covered Person suffers a loss for which Accidental Death and Dismemberment, Paralysis, Coma or Permanent and Total Disability covered under this Policy, benefits are payable under the Policy, due to or contributed by a Felonious Assault which is directed at the Policyholder, its property or assets, or the Covered Person while he or she is acting on behalf of the Policyholder as a member or representative.

Heart or Circulatory Malfunction Benefit

We will pay benefits for a Covered Person who suffers a sudden Heart or Circulatory Malfunction that results directly and independently of all other causes, from a Covered Accident and the first symptoms of the malfunction are medically diagnosed while the Covered Person is covered under the Policy and within 48 hours of a Covered Accident in the Line of Duty of the Covered Person.

Benefits will not be payable if in the past year, the Covered Person was medically diagnosed as having, or received treatment for:

- 1) a heart or circulatory malfunction; or
- 2) hypertension, angina or other heart or circulatory condition.

Accidental Burn & Disfigurement Benefit

- 1) Reconstructive or cosmetic surgery is required to restore the Covered Person's physical abilities or correct Disfigurement and must commence within 180 days of the Covered Accident; and
- 2) A Physician must determine that the burn involves the minimum percentage required, be classified as defined herein and results in Disfigurement or loss of physical abilities.

Accident Medical Expense

If the Covered Person incurs eligible medical expenses as result of a covered injury, We will pay the charges incurred for such expenses within 52 weeks, beginning on the date of the accident Payment will not exceed the maximum medical expense, subject to the deductible amount (if any). The first expense must be incurred within 60 days after the date of the accident.

Full Excess:

If a Covered Person incurs Covered Expenses, we will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor, and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable and sub-limits under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions of His primary coverage will result in a benefit reduction of Eligible Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

Adjustment Benefit

"Adjustment Expenses" are those incurred for:

- 1) Training of an Immediate Family member of the Covered Person to perform rehabilitative or custodial functions necessary to the care of the Covered Person. The first Covered Expense must be incurred within the Loss Period. Benefits will be paid for Covered Expenses that are incurred during the Benefit Period;

- 2) Travel by the Covered Person's Immediate Family members between their home and the Covered Person's place of treatment. Family travel is limited to travel by not more than two members of the Covered Person's Immediate Family at one time. Family travel by personal auto is reimbursed at mileage rates used by the Internal Revenue Service.
- 3) Lost earnings by the Covered Person's one parent or spouse, due to and in connection with the Covered Accident, will be reimbursed for up to 26 weeks, up to \$250 per week or 70% of the average weekly wage for the year preceding the Accident.

Bereavement & Trauma Counseling Benefit

If a Covered Person suffers a loss for which Accidental Death and Dismemberment, Coma, Loss of Use/Paralysis, Permanent and Total Disability, or Severe Burn (if shown as a covered benefit under this Policy) We will reimburse the Covered Person or the Covered Person's father, mother, spouse, sons, daughters, brothers or sisters for expenses incurred within one year after the date of the Accident causing such loss for any individual or family counseling sessions the maximum Benefit.

The counseling sessions must:

- 1) be required to assist the Covered Person and/or the Covered Person's father, mother, spouse, sons, daughters, brothers or sisters in coping with such loss;
- 2) be ordered and performed by a Physician; and
- 3) meet generally accepted standards of medical practice.

Only one Bereavement and Trauma Counseling Expense Benefit will be paid regardless of the number of Covered Losses/Injury incurred as the result of the same Accident.

Burial and Cremation Benefit

We will pay this benefit for burial or cremation of the Covered Person who dies from an Injury resulting directly and independently of all other causes from a Covered Accident.

Child Care Center Benefit

If a Covered Person suffers loss of life for which Accidental Death Benefits are payable under the Policy, We will pay an additional benefit on behalf of a Covered Person's covered Dependent Child who, on the date of the Accident:

- 1) was under age 13 and a Covered Person under this Policy; and
- 2) was enrolled in a Day Care Center on the date of the Covered Person's loss of life; or
- 3) subsequently enrolls within 90 days of the date of the Covered Person's loss of life in a licensed day care center.

Disability Benefit

We will pay this benefit if the Covered Person is Totally Disabled or Partially Disabled directly and independently of all other causes, from a Covered Accident. Disability benefits will begin when:

- 1) the applicable benefit waiting period if any, shown in the Schedule of Benefits, for this Policy has been satisfied; and
- 2) the Covered Person provides satisfactory proof of the Total Disability or Partial Disability to Us.

Benefit payments will end on the first of the following dates:

- 1) the date the Covered Person is no longer Totally Disabled or Partially Disabled; or
- 2) the date the Covered Person dies; or
- 3) the date the Maximum Benefit Period for this benefit ends; or
- 4) the date the Covered Person fails to submit satisfactory proof of continuing Total Disability or Partial Disability.

Education Benefit

If a Covered Person suffers loss of life for which Accidental Death Benefits are payable under the Policy, We will pay an additional benefit as shown in the Schedule of Benefits to or on behalf of his or her Dependent Child who, on the date of the Accident, was:

- 1) under age 23 and Covered Person under this Policy; and
- 2) enrolled as a full-time student in any accredited college, university or other institution of higher learning or a vocational or licensed technical school beyond the 12th grade level on the date of the Covered Person's loss of life; or
- 3) at the 12th grade level and subsequently enrolls as a full-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school within 365 days after the date of the Covered Person's loss of life.

Home Alteration & Vehicle Modification Benefit

We will pay this benefit when the Covered Person suffers a Covered Loss/Injury, other than loss of life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

- 1) prior to the date of the Covered Accident causing such a Covered Loss/Injury, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle; and
- 2) as a direct result of such Covered Loss/Injury the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
- 3) The Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Occupational HIV Benefit and Occupational Hepatitis Benefit

If a Covered Person contracts Human Immunodeficiency Virus (HIV) or develops AIDS related Complex (ARC) during the performance of any assigned occupational duties for which compensation is received from the Policyholder, We will pay a benefit if the Covered Person's coverage is in effect on the date of the Accident. It will be paid in 24 equal monthly installments.

In order to receive this Occupational HIV Benefit, the Covered Person must:

- 1) Submit a workers' compensation injury report to the Policyholder within 48 hours of the Accident; and
- 2) Submit a blood test for the Human Immunodeficiency Virus (HIV) and AIDS related Complex (ARC) within 48 hours of the Accident.

We must receive written notification of the test results, from the laboratory which performed the test, as soon as reasonably possible.

If this initial blood test is negative and the Covered Person subsequently tests positive for Human Immunodeficiency Virus.

(HIV) or AIDS related Complex (ARC) within 365 days of the Accident, We will begin monthly payments as described above.

EXCLUSIONS

- Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
- War or any act of war, declared or undeclared.
- Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
- Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
- Aggravation or re-injury of a prior injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
- Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
- Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
- Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
- Mental or nervous disorders, except as specifically provided in this policy.
- Treatment of a hernia.
- Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
- Eyeglasses, contact lenses, hearing aids.
- Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - While being used for any test or experimental purpose; or
 - While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - While traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.

Request for Policy Issue

1. Name of Volunteer Group _____
 Address _____
Street Address *City* *State* *Zip*
2. Group primarily used for: fighting fires emergency medical services other, specifically _____
3. Policy term to begin on _____ for one year.
effective date

PREMIUM CALCULATION

(Rate Chart On Back)

	BENEFIT AMOUNT	RATE
A. AD&D, with Paralysis & Coma <i>Note: The Benefit Amount selected in A will be the same Principal Sum for Optional Benefits B, C, D & E, if elected.</i>	\$ _____	\$ _____
OPTIONAL BENEFITS		
B. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
C. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
D. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
E. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
F. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	\$ _____
G. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	\$ _____
H. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
I. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
J. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
K. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
L. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	\$ _____
M. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
N. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
O. Coverage desired — <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____
1. Rate Total <i>(Add lines A through O)</i>		\$ _____
2. Number of Runs annually		× _____
3. Premium <i>(Multiply line 1 times line 2)</i>		\$ _____
Junior Firefighters and Auxiliary Coverage		
4. Coverage A Rate per Run from above		\$ _____
5. Coverage G Rate per Run from above		\$ _____
6. Total <i>(Add lines 4 & 5)</i>		\$ _____
7. Number of Runs annually		× _____
8. Total <i>(Multiply line 6 times line 7)</i>		\$ _____
9. Premium <i>(Multiply line 8 times .10)</i>		\$ _____
Total Policy Annual Premium <i>(Add lines 3 and 9)</i> <i>Subject to a minimum policy premium of \$200.00</i>		\$ _____

The undersigned hereby certifies that this information accurately represents the facts and that no requested information has been misrepresented, misstated, omitted, or altered. In the event that the undersigned becomes aware of facts that would have a material effect on the proposed coverage, any such facts or information will be immediately reported to the carrier. I understand that if information material to the underwriting of this coverage changes, the carrier reserves the right to pursue, without limitation, an adjustment of premiums or coverage in accordance with such correct facts or information and any other remedies available through operation of law or at equity.

Name: *(printed)* _____ Signature: _____
 Title: _____ Date: _____

This information is only a brief description of product features available. Coverages are subject to conditions, limitations and exclusions as contained in the policy. Product availability and plan design may vary, or not be available, depending on state laws.

Rate Chart Per Run

A. Accidental Death & Dismemberment, Paralysis & Coma

Principal Sum Amount	Rate Per Run	Principal Sum Amount	Rate Per Run	Principal Sum Amount	Rate Per Run	Principal Sum Amount	Rate Per Run	Principal Sum Amount	Rate Per Run
\$ 5,000	\$.09	\$ 15,000	\$.26	\$ 30,000	\$.55	\$ 50,000	\$.98	\$ 85,000	\$ 1.90
\$ 10,000	\$.17	\$ 25,000	\$.45	\$ 35,000	\$.60	\$ 75,000	\$ 1.55	\$ 100,000	\$ 2.25

B. Continuation of Medical/Dental Insurance Expense Benefit

Selected Principal Sum Amount from A Above	Continuation of Medical/Dental Expense Benefit Amount	Rate	Selected Principal Sum Amount from A Above	Continuation of Medical/Dental Expense Benefit Amount	Rate
\$ 5,000	\$ 750	\$.04	\$ 35,000	\$ 5,250	\$.27
\$ 10,000	\$ 1,500	\$.08	\$ 50,000	\$ 7,500	\$.38
\$ 15,000	\$ 2,250	\$.11	\$ 75,000	\$ 11,250	\$.57
\$ 25,000	\$ 3,750	\$.19	\$ 85,000	\$ 12,750	\$.64
\$ 30,000	\$ 4,500	\$.23	\$ 100,000	\$ 15,000	\$.76

G. Accident Medical Expense

Maximum Benefit Per Injury	Rate Per Run	Maximum Benefit Per Injury	Rate Per Run
\$ 500	\$ 2.19	\$ 3,500	\$ 3.37
\$ 1,000	\$ 2.44	\$ 5,000	\$ 3.48
\$ 1,500	\$ 2.96	\$ 10,000	\$ 3.66
\$ 2,000	\$ 3.06	\$ 15,000	\$ 3.77
\$ 2,500	\$ 3.19	\$ 25,000	\$ 3.99

C. Coma Benefit

Selected Principal Sum Amount from A Above	Monthly Coma Benefit Amount	Rate	Selected Principal Sum Amount from A Above	Monthly Coma Benefit Amount	Rate
\$ 5,000	\$ 250	\$.007	\$ 35,000	\$ 5,250	\$.046
\$ 10,000	\$ 500	\$.013	\$ 50,000	\$ 7,500	\$.065
\$ 15,000	\$ 750	\$.012	\$ 75,000	\$ 11,250	\$.098
\$ 25,000	\$ 3,750	\$.033	\$ 85,000	\$ 12,750	\$.111
\$ 30,000	\$ 4,500	\$.039	\$ 100,000	\$ 15,000	\$.13

H. Adjustment Expense

Benefit Amount	Rate
\$ 10,000	\$.10

I. Bereavement & Family Counseling

	Rate
Benefit Maximum: \$2,000 Benefit Period: 52 Weeks	\$.02

J. Burial & Cremation Benefit

	Rate
Maximum Benefit: \$5,000	\$.03

K. Child Care Center Benefit

	Rate
Maximum Benefit: \$2,500 per year Maximum Benefit Period: 4 years	\$.18

D. Felonious Assault and Violent Crime Benefit

Benefit Amount — Accidental Death & Dismemberment: 20% of selected Principal Sum

Principal Sum Amount	Felonious Assault & Violent Crime Benefit Amount	Rate	Principal Sum Amount	Felonious Assault & Violent Crime Benefit Amount	Rate
\$ 5,000	\$ 1,000	\$.004	\$ 35,000	\$ 7,000	\$.028
\$ 10,000	\$ 2,000	\$.008	\$ 50,000	\$ 10,000	\$.04
\$ 15,000	\$ 3,000	\$.012	\$ 75,000	\$ 15,000	\$.06
\$ 25,000	\$ 5,000	\$.02	\$ 85,000	\$ 17,000	\$.068
\$ 30,000	\$ 6,000	\$.024	\$ 100,000	\$ 20,000	\$.08

L. Total and Partial Disability Benefit

Total Disability Maximum Benefit Period: 104 weeks

Partial Disability Maximum Benefit Period: 26 weeks

Waiting Period: 7 days

Partial Disability weekly benefit is 50% of Total Disability Benefit period

Total Disability Weekly Benefit Amount	Rate	Total Disability Weekly Benefit Amount	Rate
\$ 150	\$.25	\$ 350	\$.58
\$ 200	\$.33	\$ 400	\$.66
\$ 250	\$.42	\$ 450	\$.75
\$ 300	\$.50	\$ 500	\$.84

E. Heart & Circulatory Malfunction Benefit

Benefit Amount — 50% of selected Principal Sum

Principal Sum Amount	Heart and Circulatory Benefit Amount	Rate	Principal Sum Amount	Heart and Circulatory Benefit Amount	Rate
\$ 5,000	\$ 2,500	\$.012	\$ 35,000	\$ 7,000	\$.028
\$ 10,000	\$ 2,000	\$.008	\$ 50,000	\$ 10,000	\$.04
\$ 15,000	\$ 3,000	\$.012	\$ 75,000	\$ 15,000	\$.06
\$ 25,000	\$ 5,000	\$.02	\$ 85,000	\$ 17,000	\$.068
\$ 30,000	\$ 6,000	\$.024	\$ 100,000	\$ 20,000	\$.08

M. Education Benefit

	Rate
Surviving Dependent Child Benefit Amount: \$5,000 per year Maximum Benefit period: 4 consecutive years Lump Sum benefit (if no qualified child): \$5,000	\$.18

N. Home Alteration and Vehicle Modification Benefit

	Rate
Maximum Benefit Amount: \$20,000 Maximum Benefit Period: 52 weeks	\$.04

F. Accidental Burn & Disfigurement Benefit

Principal Sum Amount Selected	Applicable Burn & Disfigurement Benefit Rate	Principal Sum Amount Selected	Applicable Burn & Disfigurement Benefit Rate
\$ 5,000	\$.03	\$ 35,000	\$.21
\$ 10,000	\$.06	\$ 50,000	\$.30
\$ 15,000	\$.09	\$ 75,000	\$.45
\$ 25,000	\$.15	\$ 85,000	\$.51
\$ 30,000	\$.18	\$ 100,000	\$.60

O. Occupational HIV and Occupational Hepatitis

	Rate
Monthly Benefit Amount: \$1,000 Maximum Benefit Period: 24 months	\$.09