VOLUNTEER GROUP—BASIC PLAN Insurance Policy Application

Print or type only

which, upon acceptance and approval by **Nationwide Life Insurance Company**—Columbus, Ohio 43216, will become a part of Indiana Volunteer Group Insurance Policy Number 802– Office Use Only

1. Name of Plan Sponsor Group's Name ____________________

Address Street ____ City ____ State ____ Zip ____ County ____

2. Name of Volunteer Group(s) ____________________

Primarily organized for (please check and complete as applicable): ☐ Fire Fighting, ☐ Ambulance Companies, ☐ Combination of Fire and Ambulance, ☐ other (specify) ____________________

Address ____________________

3. Policy Term: The policy term starts at **12:01 a.m.** on ___/_______/______ which is the effective date, and ends at **12:01 a.m.** on ___/_______/______ which is the first renewal date.

4. Schedule of Benefits

BASIC PLAN

Eligible Groups, Coverages, and Maximum Benefit Amounts
(Please check the Eligible Group(s) to be covered and the Coverages to be provided)

Benefits (Check the Weekly Total Disability Option Desired)	☐ Volunteer Emergency Group Members		☐ Auxiliary Group Members Bodily Injury/Smoke Inhalation Coverages	☐ Youth Group Members Bodily Injury/Smoke Inhalation Coverages
	☐ Bodily Injury/ Smoke Inhalation/ Cardiac Disease Event Coverages (Standard)	☐ Contagious Disease/ Infectious Disease/ Circulatory Malfunction Coverages (Supplemental)		
A. Death	$150,000	$150,000	$10,000	$5,000
B. Weekly Total Disability (Up to 260 weeks)				
☐ Option 1	250	250	Not Covered	Not Covered
☐ Option 2	300	300	Not Covered	Not Covered
☐ Option 3	350	350	Not Covered	Not Covered
C. Medical Expense	75,000	75,000	75,000	75,000
D. Permanent Total Disability	150,000	150,000	Not Covered	Not Covered
E. Permanent Physical Impairment (Face Amount)	60,000	60,000	10,000	5,000
F. Specific Loss (Face Amount)	Not Covered	Not Applicable	Not Covered	Not Covered
G. Seat Belt	Not Covered	Not Covered	Not Covered	Not Covered
H. Cosmetic Disfigurement from Burns	Not Covered	Not Covered	Not Covered	Not Covered
I. Critical Incident Stress Management Expense (Per Volunteer Emergency Group)	Not Covered	Not Covered	Not Applicable	Not Applicable
J. HIV Positive	Not Applicable	Not Covered	Not Applicable	Not Applicable
K. Daily Inpatient Indemnity	Not Covered	Not Covered	Not Covered	Not Covered
L. Education Reimbursement (Per Qualifying Dependent Per Year Up to 4 Consecutive Years)	Not Covered	Not Covered	Not Covered	Not Covered

5. Premium Rates—Fill in the current **Number of Locations, Number of Runs** made in the last **12 full months,** and current **Number of Auxiliary and Youth Groups** for the Group(s) and Coverages elected in item 4. Calculate the **Initial Premium Due** by multiplying the **Number(s)** times the applicable rates. Future premium due will be based on subsequent locations, rates and groups as applicable.

Annual Premium for BASIC PLAN		Weekly Total Disability Opt 1		Weekly Total Disability Opt 2		Weekly Total Disability Opt 3		
Volunteer Emergency Groups	Initial Numbers	Standard Coverages Only	Standard and Supplemental Coverages	Standard Coverages Only	Standard and Supplemental Coverages	Standard Coverages Only	Standard and Supplemental Coverages	Initial Annual Premium Due
First Location	1 x	$594.00	$712.00	$641.00	$769.00	$691.00	$829.00	=$
Each Add'l Location (if any)	x	297.00	356.00	320.50	384.50	345.50	414.50	=$
Each Ambulance and Rescue Squad Run	x	5.94	7.12	6.41	7.69	6.91	8.29	=$
Each Fire and other Run	x	11.88	14.25	12.82	15.38	13.82	16.58	=$
BODILY INJURY/SMOKE INHALATION COVERAGES ONLY								
Each Auxiliary Group	x	$36.00						=$
Each Youth Group	x	$24.00						=$
TOTAL INITIAL ANNUAL PREMIUM DUE (Subject to the Nonrefundable, Minimum Premium Per Policy Term of $150.00)								$

BASIC PLAN Policy Application Continued on page 4

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6. **Previous Policy Number** (if any) ____________________

7. **It is understood and agreed that:** (a) this is not a Workers' Compensation Policy; (b) the premium will be paid to us entirely by the plan sponsor with no direct contribution made by the eligible persons toward the cost of the insurance; (c) all eligible persons in the group for which coverage is elected will automatically be covered under the policy; (d) no agent may change this application, change or waive a policy provision, or accept premium in arrears; (e) the policy will not be effective unless this application is accepted and approved by Nationwide at its Home Office in Columbus, Ohio; and (f) **the Medical Expense Benefits are not payable under the policy to the extent that they are or would be collectible if the covered volunteer emergency group(s) was (were) covered by the medical treatment provision of the Indiana Workers' Compensation Act and the Indiana Occupational Diseases Act.**

8. **Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement containing any false, incomplete or misleading information is guilty of a felony.**

By sending your check to Nationwide Life Insurance Company ("Nationwide"), you give your consent to Nationwide to authorize our financial institution to convert your check into an electronic fund transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment and you will not receive a canceled check. For authorized checking account withdrawal (also called Automated Clearing House or "ACH") call 844-203-2691.

By signing below, you agree that you have read all of the Fraud Warnings provided with this application.

9.

Agent's Signature and Information	Applicant's Signature and Information
Signature & Date	Signature & Date
Printed Name	Printed Name
Agency Name	Title of Applicant
Address (Number & Street)	Address (Number & Street)
City, State, Zip	City, State, Zip
Agency Phone/Fax	Day Phone/Fax
Email/Agent Number	Email

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VOLUNTEER GROUP—DELUXE PLAN Insurance Policy Application

Print or type only

which, upon acceptance and approval by **Nationwide Life Insurance Company**—Columbus, Ohio 43216, will become a part of Indiana Volunteer Group Insurance Policy Number 802– Office Use Only

1. **Name of Plan Sponsor** Group's Name ______

Address Street ______ City ______ State ______ Zip ______ County ______

2. **Name of Volunteer Group(s)** ______

Primarily organized for (please check and complete as applicable): ☐ Fire Fighting, ☐ Ambulance Companies, ☐ Combination of Fire and Ambulance, ☐ other (specify) ______

Address ______

3. **Policy Term:** The policy term starts at **12:01 a.m.** on ___/_______/______ which is the effective date, and ends at **12:01 a.m.** on ___/_______/______ which is the first renewal date.

4. **Schedule of Benefits**

DELUXE PLAN

Eligible Groups, Coverages, and Maximum Benefit Amounts (Please check the Eligible Group(s) to be covered and the Coverages to be provided)

Benefits (Check the Weekly Total Disability Option Desired)	☐ Volunteer Emergency Group Members: ☐ Bodily Injury/ Smoke Inhalation/ Cardiac Disease Event Coverages (Standard)	☐ Volunteer Emergency Group Members: ☐ Contagious Disease/ Infectious Disease/ Circulatory Malfunction Coverages (Supplemental)	☐ Auxiliary Group Members Bodily Injury/Smoke Inhalation Coverages	☐ Youth Group Members Bodily Injury/Smoke Inhalation Coverages
A. Death	$200,000	$200,000	$15,000	$7,500
B. Weekly Total Disability (Up to 260 weeks)				
☐ Option 1	250	250	Not Covered	Not Covered
☐ Option 2	300	300	Not Covered	Not Covered
☐ Option 3	400*	400*	Not Covered	Not Covered
C. Medical Expense	75,000	75,000	75,000	75,000
D. Permanent Total Disability	150,000	150,000	Not Covered	Not Covered
E. Permanent Physical Impairment (Face Amount)	75,000	75,000	15,000	7,500
F. Specific Loss (Face Amount)	75,000	Not Applicable	15,000	7,500
G. Seat Belt	20,000	20,000	1,500	750
H. Cosmetic Disfigurement from Burns	75,000	75,000	15,000	7,500
I. Critical Incident Stress Management Expense (Per Volunteer Emergency Group)	5,000	5,000	Not Applicable	Not Applicable
J. HIV Positive	Not Applicable	75,000	Not Applicable	Not Applicable
K. Daily Inpatient Indemnity	75	75	50	50
L. Education Reimbursement (Per Qualifying Dependent Per Year Up to 4 Consecutive Years)	5,000	5,000	2,500	Not Covered

*** Weekly total disability benefit plans over $350 are subject to reduction based on income from other sources.**

5. **Premium Rates**—Fill in the current **Number of Locations, Number of Runs** made in the last **12 full months,** and current **Number of Auxiliary and Youth Groups** for the Group(s) and Coverages elected in item 4. Calculate the **Initial Premium Due** by multiplying the **Number(s)** times the applicable rates. Future premium due will be based on subsequent locations, rates and groups as applicable.

Annual Premium for **DELUXE PLAN**

Volunteer Emergency Groups	Initial Numbers		Weekly Total Disability Opt 1: Standard Coverages Only	Weekly Total Disability Opt 1: Standard and Supplemental Coverages	Weekly Total Disability Opt 2: Standard Coverages Only	Weekly Total Disability Opt 2: Standard and Supplemental Coverages	Weekly Total Disability Opt 3: Standard Coverages Only	Weekly Total Disability Opt 3: Standard and Supplemental Coverages		Initial Annual Premium Due
First Location	1	x	$691.00	$864.00	$738.00	$922.00	$806.00	$1,008.00	=	$
Each Add'l Location (if any)		x	345.50	432.00	369.00	461.00	403.00	504.00	=	$
Each Ambulance and Rescue Squad Run		x	6.91	8.63	7.38	9.22	8.06	10.07	=	$
Each Fire and other Run		x	13.82	17.27	14.76	18.45	16.12	20.15	=	$
BODILY INJURY/SMOKE INHALATION COVERAGES ONLY										
Each Auxiliary Group		x	$50.00						=	$
Each Youth Group		x	$35.00						=	$
TOTAL INITIAL ANNUAL PREMIUM DUE (Subject to the Nonrefundable, Minimum Premium Per Policy Term of $150.00)									=	$

DELUXE PLAN Policy Application Continued on page 6

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6. **Previous Policy Number** (if any) ______________________________

7. **It is understood and agreed that:** (a) this is not a Workers' Compensation Policy; (b) the premium will be paid to us entirely by the plan sponsor with no direct contribution made by the eligible persons toward the cost of the insurance; (c) all eligible persons in the group for which coverage is elected will automatically be covered under the policy; (d) no agent may change this application, change or waive a policy provision, or accept premium in arrears; (e) the policy will not be effective unless this application is accepted and approved by Nationwide at its Home Office in Columbus, Ohio; and (f) **the Medical Expense Benefits are not payable under the policy to the extent that they are or would be collectible if the covered volunteer emergency group(s) was (were) covered by the medical treatment provision of the Indiana Workers' Compensation Act and the Indiana Occupational Diseases Act.**

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By signing below, you agree that you have read all of the Fraud Warnings provided with this application.

9.

Agent's Signature and Information	Applicant's Signature and Information
Signature & Date	Signature & Date
Printed Name	Printed Name
Agency Name	Title of Applicant
Address (Number & Street)	Address (Number & Street)
City, State, Zip	City, State, Zip
Agency Phone/Fax	Day Phone/Fax
Email/Agent Number	Email

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VOLUNTEER GROUP—DELUXE PLUS PLAN Insurance Policy Application

Print or type only

which, upon acceptance and approval by **Nationwide Life Insurance Company**—Columbus, Ohio 43216, will become a part of Indiana Volunteer Group Insurance Policy Number 802– Office Use Only

1. Name of Plan Sponsor Group's Name ____________________

Address Street ____ City ____ State ____ Zip ____ County ____

2. Name of Volunteer Group(s) ____________________

Primarily organized for (please check and complete as applicable): ☐ Fire Fighting, ☐ Ambulance Companies, ☐ Combination of Fire and Ambulance, ☐ other (specify) ____________________

Address ____________________

3. Policy Term: The policy term starts at **12:01 a.m.** on ___/_______/______ which is the effective date, and ends at **12:01 a.m.** on ___/_______/______ which is the first renewal date.

4. Schedule of Benefits

DELUXE PLUS PLAN

Eligible Groups, Coverages, and Maximum Benefit Amounts (Please check the Eligible Group(s) to be covered and the Coverages to be provided)

Benefits (Check the Weekly Total Disability Option Desired)	☐ Volunteer Emergency Group Members			
	☐ Bodily Injury/ Smoke Inhalation/ Cardiac Disease Event Coverages (Standard)	☐ Contagious Disease/ Infectious Disease/ Circulatory Malfunction Coverages (Supplemental)	☐ Auxiliary Group Members Bodily Injury/Smoke Inhalation Coverages	☐ Youth Group Members Bodily Injury/Smoke Inhalation Coverages
A. Death	$250,000	$250,000	$20,000	$10,000
B. Weekly Total Disability (Up to 260 weeks)				
☐ Option 1	300	300	Not Covered	Not Covered
☐ Option 2	400*	400*	Not Covered	Not Covered
☐ Option 3	500*	500*	Not Covered	Not Covered
C. Medical Expense	75,000	75,000	75,000	75,000
D. Permanent Total Disability	150,000	150,000	Not Covered	Not Covered
E. Permanent Physical Impairment (Face Amount)	100,000	100,000	20,000	10,000
F. Specific Loss (Face Amount)	100,000	Not Applicable	15,000	10,000
G. Seat Belt	25,000	25,000	2,000	1,000
H. Cosmetic Disfigurement from Burns	100,000	100,000	20,000	10,000
I. Critical Incident Stress Management Expense (Per Volunteer Emergency Group)	5,000	5,000	Not Applicable	Not Applicable
J. HIV Positive	Not Applicable	100,000	Not Applicable	Not Applicable
K. Daily Inpatient Indemnity	100	100	75	75
L. Education Reimbursement (Per Qualifying Dependent Per Year Up to 4 Consecutive Years)	5,000	5,000	2,500	Not Covered

*** Weekly total disability benefit plans over $350 are subject to reduction based on income from other sources.**

5. Premium Rates—Fill in the current **Number of Locations, Number of Runs** made in the last **12 full months,** and current **Number of Auxiliary and Youth Groups** for the Group(s) and Coverages elected in item 4. Calculate the **Initial Premium Due** by multiplying the **Number(s)** times the applicable rates. Future premium due will be based on subsequent locations, rates and groups as applicable.

Annual Premium for DELUXE PLUS PLAN		Weekly Total Disability Opt 1		Weekly Total Disability Opt 2		Weekly Total Disability Opt 3		
Volunteer Emergency Groups	Initial Numbers	Standard Coverages Only	Standard and Supplemental Coverages	Standard Coverages Only	Standard and Supplemental Coverages	Standard Coverages Only	Standard and Supplemental Coverages	Initial Annual Premium Due
First Location	1 x	$840.00	$1,050.00	$914.00	$1,142.00	$1,014.00	$1,267.00	= $
Each Add'l Location (if any)	x	420.00	525.00	457.00	571.00	507.00	633.50	= $
Each Ambulance and Rescue Squad Run	x	8.40	10.50	9.14	11.42	10.14	12.67	= $
Each Fire and other Run	x	16.80	21.00	18.28	22.84	20.28	25.34	= $
BODILY INJURY/SMOKE INHALATION COVERAGES ONLY								
Each Auxiliary Group	x	$65.00						= $
Each Youth Group	x	$45.00						= $
TOTAL INITIAL ANNUAL PREMIUM DUE (Subject to the Nonrefundable, Minimum Premium Per Policy Term of $150.00)								= $

DELUXE PLUS PLAN *Policy Application Continued on page 8*

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6. **Previous Policy Number** (if any) ____

7. **It is understood and agreed that:** (a) this is not a Workers' Compensation Policy; (b) the premium will be paid to us entirely by the plan sponsor with no direct contribution made by the eligible persons toward the cost of the insurance; (c) all eligible persons in the group for which coverage is elected will automatically be covered under the policy; (d) no agent may change this application, change or waive a policy provision, or accept premium in arrears; (e) the policy will not be effective unless this application is accepted and approved by Nationwide at its Home Office in Columbus, Ohio; and (f) **the Medical Expense Benefits are not payable under the policy to the extent that they are or would be collectible if the covered volunteer emergency group(s) was (were) covered by the medical treatment provision of the Indiana Workers' Compensation Act and the Indiana Occupational Diseases Act.**

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By signing below, you agree that you have read all of the Fraud Warnings provided with this application.

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Agent's Signature and Information	Applicant's Signature and Information
Signature & Date	Signature & Date
Printed Name	Printed Name
Agency Name	Title of Applicant
Address (Number & Street)	Address (Number & Street)
City, State, Zip	City, State, Zip
Agency Phone/Fax	Day Phone/Fax
Email/Agent Number	Email

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Death Benefit

If, as a result of injury, an insured dies, we will pay in one lump sum, the applicable death benefit.

Weekly Total Disability Benefit

If, as a result of injury, an insured becomes totally disabled, we will pay the applicable amount (except elected benefits over $350 weekly are subject to reductions — see below) on the following basis:

1. benefits start on the first day of total disability;
2. if payment is for part of a week, the daily rate is 1/7 of the weekly benefit;
3. benefits will end on the first of these to occur:
   (a) the death of the insured;
   (b) when the total disability ends; or
   (c) when the number of weeks for which benefits have been paid equals 260.

Total disability or **totally disabled** for this benefit means disability caused by an injury:

1. which keeps the insured from pursuing his or her usual vocation; and
2. during which the insured is under the regular care of a physician.

Reductions apply ONLY if the elected weekly benefit is over $350 and mean that the total disability amount otherwise payable to an insured will be reduced so that the total amount payable, plus all of the insured's income from other sources, is no more than:

1. **80% of his or her average weekly earned income; or**
2. **$350 per week, whichever is greater.**

Income from other sources means periodic benefits for loss of time payable or provided for the same period of disability or a part of that period under:

1. another insurance contract or retirement plan;
2. an employer, labor management and/or union sponsored salary continuance, disability or retirement plan;
3. Workers' Compensation, Unemployment Compensation or similar occupational laws; and
4. the Social Security Act, the Railroad or Civil Service Retirement Act and the compulsory state disability benefit laws or any other loss of time or retirement plan provided by a government authority of any country (including any state, province, or other political subdivision).

Increases in the amount paid under items (3) and (4) above which occur after the benefit period begins will not be used to further reduce the amount we will pay.

Average weekly earned income means average weekly earnings produced by the sum of (1) and (2) below:

1. the greatest of all wages, salaries, bonuses, tips, and commissions determined as follows:
   (a) the calendar year immediately preceding the year in which total disability occurs divided by 52; or
   (b) the 12-month period immediately preceding the date total disability occurs divided by 52; or
   (c) the three-month period immediately preceding the date total disability occurs divided by 13; and
2. the net earnings from self-employment for which Federal self-employment taxes were paid, as shown on the filed tax return for the calendar year immediately preceding the year in which total disability occurs, divided by 52.

Medical Expense Benefit

If, as a result of injury, an insured incurs covered expenses, we will pay up to the applicable amount, for all such covered expenses incurred.

Covered expenses for this benefit mean:

1. the reasonable and customary charges for which an insured is required to pay for licensed ambulance service to and/or from a hospital, medical center, rehabilitation center, skilled nursing and sub-acute care facility, or surgical center; and
2. the following reasonable, customary and medically necessary charges for services, supplies and treatment provided or prescribed by a physician for which an insured is required to pay for:
   (a) hospital, medical center and surgical center care;
   (b) rehabilitation center care and skilled nursing and subacute facility care;
   (c) medical care (including second and third opinions);
   (d) nursing care provided by licensed nurses;
   (e) X-rays and lab tests;
   (f) prescription drugs and therapeutic services and supplies;
   (g) prosthetic devices (excluding subsequent repairs and replacements);
   (h) orthopedic appliances necessary to promote healing;
   (i) dental care (including tooth replacement but excluding subsequent repairs and replacements) as a result of injury to sound, natural teeth; and
   (j) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or nursing home confinement:
      (i) physical, occupational, respiratory, and speech therapy;
      (ii) the services of a home health aide; and
      (iii) medical supplies.

No benefits are payable for medical expenses to the extent they are or would be collectible under the medical treatment provisions of the Indiana Workers' Compensation Act and the Indiana Occupational Diseases Act, whether enrolled or not enrolled.

Permanent Total Disability Benefit

If, as a result of injury, an insured becomes totally disabled for 260 continuous weeks **and during such time has taken part in an occupational rehabilitation program that we approve (if his or her condition so warrants)** and is thereafter totally disabled as defined in item 2 below, we will pay in one lump sum, the amount which applies.

Total disability or **totally disabled** for this benefit means disability caused by an injury:

1. which, throughout the first 260 continuous weeks, keeps the insured from pursuing his or her usual vocation;
2. which, after the first 260 continuous weeks of disability:
   (a) keeps the insured from performing the substantial and material duties of any job for which he or she is reasonably suited or qualified by education, training, or experience; and
   (b) it is determined by competent medical authority that the disability is permanent; and
3. during which the insured is under the regular care of a physician.

Permanent Physical Impairment Benefit

If, as a result of injury, an insured is permanently physically impaired, we will pay in one lump sum, a percent of the face amount; **provided the insured has taken part in a physical rehabilitation program that we approve, if his or her condition so warrants.**

An examining physician will assign to an insured an impairment value. This value is expressed as a percentage in relation to the whole person. The impairment is determined by the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. This value is applied to the face amount shown in the application to determine the dollar amount payable.

All claims must be verified by agreement between a physician chosen by the insured and one chosen by us. If the two physicians cannot reach an agreement, a third physician, agreed upon by both physicians, will be consulted. The majority decision of the three will be binding on both the insured and us.

If the insured already had a physical impairment before the time of the loss, the impairment value that represents the preexisting condition will be deducted from the Permanent Physical Impairment evaluation. If benefits are paid or payable for the same body part under this benefit and the Specific Loss Benefit for any one accident, only one benefit, the largest, applies.

If benefits are paid or payable under more than one of the benefit sections titled Death, Permanent Physical Impairment, Specific Loss or Cosmetic Disfigurement from Burns for an insured for any one injury, the sum of all such benefits will not exceed the insured's Death Benefit maximum.

Specific Loss Benefit

If, as a result of injury, an insured suffers one or more specific losses within one year after the date of the accident causing the injury, we will pay in one lump sum a percent of the face amount as specified in the following Table.

Specific Loss	% of Face Amount
Each Arm	75%
Each Leg	75%
Each Hand	50%
Each Foot	50%
Sight of Each Eye	50%
Speech	50%
Hearing of Each Ear	25%
Thumb and Index Finger of Same Hand	25%
Each Thumb	5%
Each joint of a Thumb, Finger or Toe	1%

The total payment for all of the losses of an insured because of any one occurrence will not be more than the face amount shown in the application. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies to the same limb. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies to the same limb.

Specific loss means:

1. the actual, total, permanent and irrecoverable loss of a natural:
   (a) arm or leg completely severed at or above the elbow or knee joint;
   (b) hand or foot completely severed at or above the wrist or ankle joint;
   (c) thumb and index finger of the same hand completely severed at or above the joints that attach them to the hand;
   (d) thumb completely severed at or above the joint that attaches it to the hand;
   (e) joint of a thumb, finger or toe completely severed at or above the joint; or
2. the actual, total, uncorrectable, permanent and irrecoverable loss of the entire:
   (a) sight of a natural eye;
   (b) natural speech; or
   (c) hearing of a natural ear.

The total payment for all of the specific losses of an insured because of any one accident will not be more than 100% of the face amount which applies.

Only one benefit, the largest, is payable for the loss of multiple body parts of the same limb. For example, since the loss of the hand automatically means the loss of the fingers, thumb and joints of the thumb and fingers, only the hand benefit is payable as it is the largest.

If benefits are paid or payable for the same body part under

this benefit and the Permanent Physical Impairment Benefit for any one accident, only one benefit, the largest, applies.

If benefits are paid or payable under more than one of the benefit sections titled Death, Permanent Physical Impairment, Specific Loss or Cosmetic Disfigurement from Burns for an insured for any one injury, the sum of all such benefits will not exceed the insured's Death Benefit maximum.

Seat Belt Benefit

If the death benefit is payable on an insured, we will pay in one lump sum, the amount which applies; provided that at the time of the covered activity involved, the insured was using a properly fastened seat belt while operating or riding as a passenger in a land motor vehicle. Actual seat belt usage must be verified by either a person of competent authority (such as, but not limited to, an investigating officer, a physician, or a coroner) or by other reasonable proof satisfactory to us.

Seat belt means any factory, manufacturer or government authorized dealer installed passive restraint device that meets published national government safety standards. An air bag, without use of a lap and shoulder belt, is not considered a passive restraint device under this benefit.

Cosmetic Disfigurement from Burns Benefit

If, as a result of injury, an insured suffers a cosmetic, nonfatal third degree burn or full thickness burn, we will pay in one lump sum, a percent of the maximum benefit amount which applies based on the Table below. The amount payable is based on the body surface area burned (as a percent of total body surface area) multiplied by the Location Factor shown in the following Table.

Body Location	Location Factor
Face	10
Head (including Scalp and Neck)	7
Hand	5
Arm	3
Chest, Back or Abdomen	2
Leg or Foot	1

***Example:* An insured suffers a cosmetic nonfatal full thickness burn to the face and hand. It is determined that the facial injury is 5% of the total body surface area and the hand injury is 2%. The benefit payment would be:**

Body Location	% of Body Surface Area	Location Factor	% of Max Benefit
Face	5% x	10	=50%
Hand	2% x	5	= 10%
		Total Benefit Payable	**= 60%**

If benefits are paid or payable for the same body part under this benefit and the Specific Loss Benefit for any one accident, only one benefit, the largest, applies. **However, in no event will the sum of all benefits payable under the benefit sections titled Death, Permanent Physical Impairment, Specific Loss and Cosmetic Disfigurement from Burns exceed the insured's Death Benefit maximum.**

Critical Incident Stress Management Expense Benefit

We will pay reasonable covered expenses incurred by a Critical Incident Stress Management Team, not to exceed the amount which applies, when such services:

1. are requested and authorized by the covered volunteer emergency group; and
2. are required as a result of one or more insureds participating in a covered activity.

Covered expenses for this benefit mean reasonable and necessary transportation, meals, and lodging expenses incurred by the Critical Incident Stress Management Team within 60 days after the covered activity.

HIV Positive Benefit

If, as a result of injury, an insured tests HIV positive, we will pay in one lump sum, the amount which applies, subject to the following requirements:

1. an incident report (notice of exposure), in a form acceptable to us, describing the nature of the exposure to HIV, must be filed with the plan sponsor and sent to us within 10 days of the later of when the insured:
   (a) participated in the emergency situation causing the exposure; or
   (b) received notice that a treated patient either:
      (i) has tested HIV positive, or
      (ii) is believed by competent medical authority to have a reasonable possibility of having contracted HIV, even though the medical authority is unable to conduct appropriate HIV tests accordingly;
2. the insured must have a preliminary screening test, such as an ELISA or other appropriate Food and Drug Administration (FDA) approved test, for HIV within seven days of filing the incident report described in item 1 above. We must receive notification of the test results as soon as reasonably possible and the results must be negative (or if positive, a confirmation test such as the Western Blot method must be negative); and
3. subsequently, the insured must test HIV positive via both a positive screening test enzyme-linked immunosorbent assay (ELISA) and a positive supplement test such as the Western Blot method within one year after the date of participating in the covered emergency situation causing the exposure to HIV. We must receive notification of the positive test results as soon as reasonably possible.

In addition, we will pay the reasonable and customary charges for each of the following:

(A) HIV tests required in item 2 above; and

(B) up to two subsequent HIV tests performed at reasonable intervals, provided said tests are performed at least 60 days but no later than one year after the date of the exposure referred to in item 1 above.

HIV means human immunodeficiency virus.

HIV positive means the presence of HIV antibodies in the blood of an insured as substantiated through both a

positive screening test enzyme-linked immunosorbent assay (ELISA) and a positive supplemental test such as Western Blot. All such tests must be approved by the FDA, with the interpretation of positivity as specified by the manufacturer(s).

Treated patient means a person with whom an insured came in contact in an emergency situation and who either:

1. has tested HIV positive; or
2. is believed by competent medical authority to have a reasonable possibility of having contracted HIV, even though the medical authority is unable to conduct appropriate HIV tests accordingly.

Benefits are not payable for HIV, acquired immune deficiency syndrome (aids), aids related complex (arc), or any complications arising therefrom, under any provision of this policy, except as specifically provided for in this benefit.

Daily Inpatient Indemnity Benefit

If, as a result of injury and on the advice of a physician, an insured is initially confined as an inpatient in an institution within 100 days after the date of the covered activity involved, we will pay, for one or more such inpatient confinements for up to three years after the date of the covered activity, the daily amount which applies for each day of such inpatient confinement as a result of such injury. The inpatient confinement(s) must be medically necessary. The number of days payable applies only once for any one injury. The institution must charge for a full day of inpatient confinement for benefits to be payable for the day.

Inpatient means a resident patient using and being charged for the room and board facilities of the institution. Outpatient and emergency room treatments are not inpatient confinement.

Institution means a properly licensed hospital, rehabilitation center, and/or skilled nursing and sub-acute care facility. The term "institution" does not include, other than incidentally, a place for: rest, custodial care, the aged, drug addicts or alcoholics.

This benefit:

1. starts on the first day of inpatient confinement; and
2. ends on the first of these to occur:
   (a) when the inpatient confinement ends; or
   (b) when the total number of days for which benefits have been paid because of all of his or her inpatient confinements resulting from the injury equals 365.

Education Reimbursement Benefit

If the death benefit is payable on an insured, we will reimburse covered expenses **(net of scholarships, grants, awards, and other assistance)** charged by an institution of higher learning, up to the annual amount which applies per spouse and per dependent child. To qualify, an insured's spouse must be enrolled in an institution of higher learning either at the time of the insured's death or within one year thereafter. Each dependent child must be enrolled in an institution of higher learning beyond the 12th grade level either at the time of the insured's death or within one year thereafter. Qualified persons are reimbursed for covered expenses at the end of each school term, subject to receipt of copies of the proper billings and verification of course completion.

Covered expenses for this benefit mean the cost of tuition, application fees, matriculation fees, and lab fees for the current enrolled school term **(but excluding room and board charges, textbooks and supplies, interest charges, late fees, parking fees and similar fees and charges)** at an institution of higher learning up to the annual amount shown in the application per spouse and per dependent child; provided the cost for such spouse or dependent child is incurred during the four consecutive years following the insured's death.

Dependent child for this benefit means, at the time of the insured's death, an unmarried child, under 25 years of age, who is dependent upon the insured for at least 50% of his or her maintenance and support. The term "dependent child" includes the insured's stepchild, legally adopted child, a child under the insured's legal guardianship and a grandchild who permanently resided with the insured at the time of the insured's death.

Institution of higher learning means, but is not limited to, a state or private university or college as well as a professional or trade school.

Policy exclusions & Limitations

We will not pay benefits for expenses incurred for:

(1) the examination, prescription, purchase or fitting of eyeglasses, contact lenses or hearing aids; or

(2) treatment by a person employed or retained by the plan sponsor or its subsidiaries or affiliates and for which no charge is normally made; or

(3) care or treatment by a person who ordinarily lives in the insured's home or is a parent, grandparent, spouse, brother, sister or child of either the insured or the insured's spouse (if a NJ contract, care or treatment furnished by a member of the insured's immediate family).

Nor will we pay benefits for loss or expenses resulting from:

(4) intentional self-destruction or an attempt at it, or intentional self-inflicted injury (if MO contract, while sane);

(5) war or an act of war, declared or undeclared; or

(6) air travel unless the insured is a passenger on a regularly scheduled flight of a properly licensed commercial airline; or

(7) a heart or circulatory malfunction if the insured has either received prior medical treatment for or has been medically diagnosed (medically diagnosed not applicable in a MO contract) to have had a heart or circulatory malfunction within the last five years [item (7) is not applicable in a PA or VA contract].

How do you apply and pay for coverage?

Complete ALL fields on the application. Be sure to sign and date where indicated. **We need to receive the completed application and premium payment BEFORE the desired policy effective date.**

APPLICATION OPTIONS

Online at nationwide.com/grouprotector

Mail the application and Premium Report, if applicable, to GrouProtector / K&K Insurance Group, Inc., PO Box 2338, Fort Wayne IN 46801

E-mail: Scan the application and Premium Report, if applicable and email them to grouprotector@kandkinsurance.com. Include payment by filling out, scanning and emailing the ACH form or submit payment with a credit or debit card. If you prefer, you may mail a check (see below).

Fax: the application and Premium Report, if applicable, to 260-459-5903. Submit payment by credit or debit card, ACH, or if you prefer you may mail a check (see below).

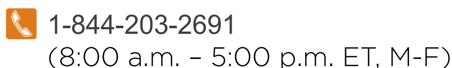
PAYMENT OPTIONS

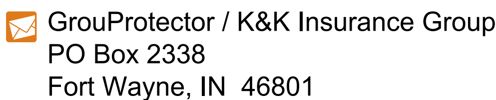
Pay by mail: Mail payment to GrouProtector c/o K&K Insurance Group, Inc., PO Box 2338, Fort Wayne, IN 46801

Pay by credit or debit card: Call (844) 203-2691

Pay by electronic check (ACH): Download and complete the Automated Clearing House (ACH) Authorization Form found at nationwide.com/ach and mail, fax or e-mail the ACH form with your application.

How do you contact us?





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Fraud Warnings

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

Please read these important notices and warnings

All cases are subject to the acceptance of the risk and may be subject to review of prior claims experience.

Unless otherwise specified in the Benefit Provisions, this policy does not provide coverage for sickness or for legal liability.

This policy does not provide basic hospital, basic medical or major medical insurance.