



AmFirst Insurance Company Ltd. Cash Value Executive Disability Plan

Schedule of Benefits

The benefit amounts payable under this Insurance are shown in the Certificate of Coverage. Monthly Disability Benefits, Monthly Loss of Use Benefits and Lump Sum Benefits are subject to the Terms, Conditions Provisions, Definitions and Exclusions this Policy.

MONTHLY DISABILITY BENEFIT

Monthly Disability Benefits will be paid by the Company to an Insured Person when an Insured Person is continuously Disabled after the Insured Person has satisfied the Waiting Period and the Elimination Period of ninety (90) days. Monthly Disability Benefits will not exceed the maximum Monthly Disability Benefits shown in the Certificate of Coverage and such payments will not exceed the Maximum Benefit Period of thirty-six (36) months. Monthly Disability Benefits are **not** in addition to Monthly Loss of Use Benefits

MONTHLY LOSS OF USE BENEFIT

Monthly Loss of Use Benefits will be paid by the Company to an Insured Person when the Insured Person has satisfied the Waiting Period and the Elimination Period of ninety (90) days. Monthly Loss of Use Benefits will not exceed the maximum Monthly Loss of Use Benefits shown in the Certificate of Coverage and such payments will not exceed the Maximum Benefit Period of thirty-six (36) months if Accidental Injury caused an Insured Person to experience any of the following within three-hundred and sixty-five (365) days after the Accident:

Loss of Use of:

1) One Hand, or 2) One Foot, or 3) One Arm, 4) One Leg, or 5) Sight of Both Eyes.

Monthly Loss of Use Benefits are **not** in addition to Monthly Disability Benefits and are payable only once per Insured during the time that this policy is in force.

LUMP SUM DISABILITY BENEFIT

If the Company has paid to the Insured Person either the Monthly Disability Benefit or the Monthly Loss of Use Benefit, not both, for the Maximum Benefit Period and at the expiration of such Maximum Benefit Period the Insured Person is still Disabled as a result of the same Accident or Illness, the policy will then pay to the Insured Person a Lump Sum Benefit equal to:

100 times the Monthly Disability Benefit chosen by the Insured Person on the application for coverage; (Example: If the Monthly Disability Benefit chosen by the Insured Person is \$5,000, then after being continuously Disabled for 36 months this policy will pay a Lump Sum Benefit of \$500,000); or

30 times the Monthly Loss of Use Benefit chosen by the Insured Person on the application for coverage. (Example: If the Monthly Loss of Use Benefit chosen by the Insured Person is \$5,000, then after being continuously Disabled for 36 months this policy will pay a Lump Sum Benefit of \$150,000). The Loss of Use Lump Sum Benefit is payable only once per Insured during the time that this policy is in force.

Only one (1) Lump Sum Benefit is collectable following either Monthly Disability Benefits or Monthly Loss of Use Benefits.

CASH VALUE BENEFIT

This policy will pay You a Cash Value Benefit beginning on the day after the Tenth Anniversary Date. The Cash Value Benefits paid will be the Original Premium paid less any Claims Paid multiplied by fifty (50) percent. If the policy has been in force for at least fifteen (15) consecutive years and the Insured Person attains the age of sixty-five (65), then the Cash Value Benefit will equal one-hundred (100) percent of the Original Premium paid less any Claims Paid.

INSURING AGREEMENT

The Company promises to pay You, the Insured, the benefits provided by this policy provided, that the Insured Person has a) sustained a Bodily Injury or b) suffers Illness. All benefits are subject to the Certificate of Coverage, Schedule of Benefits, Policy Provisions, Policy Definitions, General Conditions, General Exclusions, Specific Exclusions, Policy Endorsements and Amendments.

CONSIDERATION

This policy is issued in consideration of the application and payment of the initial premium. Premiums must be paid in U. S. dollars. The initial premium does not constitute the automatic acceptance of the application nor the admission into the insurance plan. The acceptance of an applicant is based on the Company's underwriting criteria. In the event an application is declined, the Company's responsibility is limited to written notification to the applicant, and the total reimbursement of the initial premium.

COMMENCEMENT OF COVERAGE

Insurance coverage is provided after the application has been reviewed and accepted, the policy issued, the premium has been paid to the Company in accordance with the mode of payment specified on the Certificate of Coverage page, and the Insured Person(s) have satisfied the Active Provision.

TEN DAY RIGHT TO RETURN POLICY

If for any reason You are not satisfied with this policy, You may return it to the Company within ten (10) days after You receive it. You must return it to us by mail or to the broker who sold it to You. The Company will then refund any premium paid and the policy will be deemed void, just as though no policy had been issued.

EFFECTIVE DATE

This policy begins at 12:01 a.m. Standard Time at Your residence on the Policy Effective Date shown in the Certificate of Coverage. It ends at 12:01 a.m. on the date any renewal premium is due.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Check to see if any medical history has been omitted. Write to the Company within ten (10) days if any information shown is incorrect or incomplete. This policy is issued on the basis that the answers to all questions are correct and complete. Any omissions or incorrect statements could cause the Company to deny benefits, to endorse, to amend, or to rescind the Insured Person(s) coverage.

Chairman



AmFirst Insurance Company Ltd.

POLICY PROVISIONS

POLICY ADMINISTRATION

The Policy Provisions, Certificate of Coverage, Schedule of Benefits, Application for Coverage, Policy Definitions, General Conditions, General Exclusions, Specific Exclusions, and any Amendments or Endorsements attached to the contract constitute the Entire Contract between the parties. The English version shall be the official version and the terms of the English language version shall control. The Company may change the administrative procedures by written notice.

AUTHORITY

No agent, broker, or any other person has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid unless approved in writing by an officer of the Company and such approval be endorsed on the policy or by amendment signed by a Company officer.

PAYMENT OF CLAIMS

The Company will make all payments of claims directly to the Insured. Submission of a fraudulent claim will be grounds for cancellation of the policy by the Company.

FILING A CLAIM

Notice of a claim must be given within twenty-one (21) days from the onset of a Disability by telephone, email, facsimile or in writing to the Company at the address of its administrator, **Morgan-White Administrators International, Inc.**, (address, telephone number, facsimile number and email address can be found on page 11 of this policy) or to a claims office in your local area appointed by the Company. **Failure to provide notice of claim within twenty-one (21) days from the onset of Disability shall serve to invalidate your claim.** Upon notice from You of such Disablement the Company will provide You with a claim form for filing proof of loss. The claim form must be completed and returned to Morgan-White Administrators International Inc., within twenty-one (21) days from the date it was sent to You. Benefits payable under this policy for any loss will be paid to You at such time as the Company has substantiated the loss and will be paid in U.S. Dollars.

SUBROGATION

In the event You suffer a loss as a result of negligence, wrongdoing or other liability of a third party, the Company has a right to recover and be reimbursed for any claim payments it has made on Your behalf, to the extent that You have received partial or full recovery from any liable third party for such loss. This right is known as subrogation. The Company has the right to proceed at its own expense in the name of the Insured Person, against third parties who may

be responsible for causing a claim under this policy, or who may be responsible for providing indemnity or benefits similar to this insurance. The Company has full rights of subrogation

PHYSICAL EXAMINATIONS

The Company, at its own expense, shall have the right and opportunity to have a Physician examine any Insured whose Bodily Injury or Illness is the basis of claim when and as often as it may be reasonably required while a claim is pending. The Insured shall make available to the Company all medical reports and records, and when required, shall sign all authorization forms necessary to give the Company a full and complete medical history. The refusal of your Doctor or hospital to make all medical reports and records available to the Company could cause an otherwise valid claim to be denied or the claim to be closed due to no or insufficient reply from the Insured's medical providers.

DISPUTES AND LEGAL ACTIONS

The parties hereon agree that any and all disputes, claims, or controversies arising out of or relating to this policy, or its alleged breach, that are not resolved by the parties hereon, shall be submitted to final and binding arbitration. Such arbitration shall be conducted in the City of Hamilton, Bermuda in accordance with Commercial Arbitration Rules of the American Arbitration Association, and judgement on any award rendered in such arbitration may be entered in any state or federal court in such City. Such arbitration shall be the sole remedy for any disputes, claims or controversies on this policy. Notices in connection with such arbitration and process in any judicial proceeding in connection herewith may be served by personal delivery or registered mail or via courier to the Company at its home office, and to the Insured at the most current address appearing on the records of the Company, with the same effect as if personally served, sent by registered mail or via courier in such City. The Insured must file the request for arbitration to the Company within one hundred and eighty (180) days of the event which brought about the dispute, claim or controversy between the parties hereon. **Failure of the Insured to give such notice to the Company within the one hundred and eighty (180) day period will relieve the Company of any and all liability for the dispute, claim or controversy.** The Company's liability in any such arbitration shall be limited to such amounts that are specified under this policy, with such interest thereon and such costs of the arbitration proceeding, if any, as the arbitrators may direct. In no event shall the Company be liable for any extra-contractual damages, whether characterized, without limitation, as consequential, exemplary, punitive or tort damages, for any disputes, claims or controversies arising out of or relating to this policy.

ELIGIBILITY

To become eligible for this insurance You must:

- 1) be less than 61 years old,
- 2) not be a permanent resident or de facto permanent resident of the U.S.A., and
- 3) must meet the Active Provision and Effective Date Requirement of this policy.

This policy is not available to any resident of the United States of the America and has not been filed with or approved by any insurance regulatory authority in the United States of America.

MONTHLY DISABILITY BENEFITS

The Monthly Disability Benefit amounts payable under this Insurance are shown in the application for coverage and, Certificate of Coverage page. Monthly Disability Benefits are subject to the Policy Provisions, General Conditions, General Exclusions, Policy Definitions, and Specific Exclusions of this policy

SUCCESSIVE PERIODS OF DISABILITY

During a period of Disability, the Company will consider such Disablement continuous, if other Accidents or Illnesses caused it to continue. A continuous period of Disability concludes when the Insured Person is no longer considered Disabled. Successive periods of Disability will be considered as one period of Disability unless they are due to unrelated causes or separated by a time when the Insured Person is able to perform four or more of the Activities of Daily Living. A separate Elimination Period will apply for each separate period of Disability.

LUMP SUM DISABILITY BENEFITS

If the Company has paid to the Insured Person, the Monthly Disability Benefit for the Maximum Benefit Period and at the expiration of such Maximum Benefit Period the Insured Person is still Disabled as a result of the same Accident or Illness, the policy will then pay to the Insured Person a Lump Sum Benefit equal to one hundred (100) times the Monthly Disability Benefit chosen by the Insured Person on the application for coverage. (Example: If the Monthly Disability Benefit chosen by the Insured Person is \$5,000, then after being continuously disabled for thirty-six (36) months this policy will pay a Lump Sum Benefit of \$500,000). See Termination of Disability Monthly Benefits due to the Insured Person becoming age 65.

TERMINATION OF MONTHLY DISABILITY BENEFITS

Monthly Disability Benefits will cease for an Insured Person on the earliest of:

- 1) the date on which the Insured Person is no longer Disabled,
- 2) the date on which an Insured Person may die,
- 3) the Maximum Benefit Period has been exhausted,
- 4) the Company determines a misrepresentation has been made.
- 5) the Premium is not paid.
- 6) **the anniversary date of the policy after the Insured Person becomes sixty-five (65) years old.**

If a disabled Insured person becomes sixty-five (65) years old and the Monthly Disability Benefits are terminated prior to thirty-six (36) consecutive Monthly Disability Benefits being paid, then the Lump Sum Benefit will not be paid.

ACTIVE PROVISION

The Insured Person must be active on the scheduled Effective Date of coverage. If the Insured Person does not meet the Active Provision of the policy, the coverage will not become effective until such time as the Insured Person is actually active.

GOVERNING LAW

Any matters relating to interpretation of this policy including any matters relating to the representations of the Insured in connection with the application for coverage or issuance of this policy shall be resolved in accordance with the laws Bermuda.

TERMINATION OF THE POLICY

This policy will terminate on the earlier of:

1. The primary Insured attains the age of sixty-five (65).
2. The primary Insured surrenders this policy.
3. The primary Insured's death and the Dependents decided not to continue the policy.
4. Your failure to pay the premium for this policy.
5. All monthly benefits under this policy have been paid and all Lump Sum Benefits have been paid.
6. When Claims Paid equal or exceed the Cash Value Benefit of this policy.
7. The primary Insured's death, in which case, any Cash Value Benefit due (if any) will be paid to Your estate or beneficiary.

SEVERABILITY

If any provision of this policy is found to be unenforceable, such provision shall be considered severed from the remaining provisions of this policy and such remaining provisions shall be and remain in full force and effect.

RENEWAL CONDITIONS

This policy is an annual contract which, until terminated, may be renewed on the anniversary date as provided below:

- (1) If no notice of cancellation has been given by either party at least one month prior to renewal,
- (2) the premium due has been paid to the Company prior to the expiration date, and
- (3) no condition of this policy has been breached by the Insured.

The Company through an appointed broker shall offer to renew this policy at rates and on the terms prevailing at the time for the class of the Insured.

Such offer may be accepted by payment of the renewal premium within thirty (30) days of the renewal date. Upon payment for each renewal a new Certificate of Coverage will be issued as evidence that insurance is in force. If these conditions are not met, the policy is terminated.

The Company agrees that no individual Insured Person shall be independently penalized by cancellation of the policy or rate increase due to a poor claims record. Any policy cancellations or rate increases will only be made by Class of Insured not by individual Insured.

PAYMENT OF LOSS OF USE BENEFITS

Accidental Loss of Use Monthly Benefits will be paid as follows:

The Accidental Loss of Use Benefit amounts payable under this policy will be equal to the Monthly Disability Benefits chosen in the Application for Coverage and which is shown on the Certificate of Coverage. Monthly Disability Benefits Monthly Loss of Use Benefits are subject to the Terms, Conditions, Policy Provisions, Definitions and Exclusions of the policy.

Monthly Loss of Use Benefits under this policy will be paid by the Company when an Insured Person has experienced a Loss of Use as defined. The Monthly Loss of Use Benefit is payable after an Insured Person has satisfied the Waiting Period and the Elimination Period of ninety (90) days. Monthly Loss of Use Benefits will not exceed the Maximum Monthly Disability Benefits shown on the Certificate of Coverage and such payments will not exceed the Maximum Loss of Use Benefit Period of thirty-six (36) months. Under no circumstance will the Monthly Loss of Use Benefits exceed US\$5,000, even if the Monthly Disability Benefit chosen for the policy and shown on the Certificate of Coverage is greater than US\$5,000. **(Example:** If an Insured Person chooses the US\$7,000 Monthly Disability Benefit the Maximum Monthly Loss of Use Benefit can be only US\$5,000).

REINSTATEMENT PROVISIONS

If this policy terminates because a premium is not paid by the end of the Grace Period, You may apply to reinstate this policy at anytime until the first unpaid premium is ninety (90) days past due. In order to reinstate this policy, three requirements must be met:

1. You must submit a reinstatement application with evidence of Your insurability; and
2. the Company must approve the reinstatement application; and
3. You must submit the full amount of the overdue premium.

If the company approves the reinstatement application, this policy will be reinstated on the approval date and the policy will not cover:

1. Illness which first manifests itself within thirty (30) days from date of reinstatement; and
2. Any condition which is excluded by name or description. In all other respects, You and the Company shall have the same rights thereunder as we each had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

CASH VALUE BENEFIT - PAYMENT OF BENEFIT

The Cash Value Benefit will be paid if any of the following conditions are met:

1. You attain the age of sixty-five (65).
2. You surrender the policy after the Tenth Anniversary Date.
3. You die after the Tenth Anniversary Date.
4. You fail to pay premium required to keep this policy in force after the Tenth Anniversary Date.
5. The policy terminates after the Tenth Anniversary Date.

CASH VALUE BENEFIT - CLAIMS

If a claim is Incurred on a date when the Cash Value Benefit would otherwise be payable regardless of whether it has been reported or adjudicated, the Company will:

1. Pay the claim, and then reduce the Cash Value Benefit by the sum of all Claims Paid.
2. Pay the Cash Value Benefit and then reduce the claim by the amount of the Cash Value benefit.
3. Pay the Cash Value Benefit if the claim is not payable based on the terms of the policy.

POLICY DEFINITIONS

The following provisions and definitions apply to this policy :

1. **ACCIDENT/ACCIDENTAL** means any sudden and unforeseen event occurring during the policy period resulting in Bodily Injury independent of disease or bodily infirmity, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.
2. **ACTIVE PROVISION** means the Insured Person is able to perform all of the Activities of Daily Living.
3. **ACTIVITIES OF DAILY LIVING** mean activities, used in measuring levels of personal functioning capacity. These activities are performed without Assistance from another individual, allowing personal independence in everyday living. The six Activities of Daily Living are:
 - a) **Continance:** the ability to voluntarily control bowel and bladder function, or, in the event of incontinence, the ability to maintain a reasonable level of control;
 - b) **Transferring:** the ability to move in and out of a chair or bed without equipment such as walkers, crutches, or grab bars or other support devices;
 - c) **Dressing:** putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as artificial limbs or splints;
 - d) **Toileting:** getting on or off and to and from the toilet or commode, to maintain a reasonable level of personal hygiene and to care for clothing;
 - f) **Eating:** the ability to get nourishment into the body by any means once it has been prepared and made available to You;
 - g) **Bathing:** the ability to wash yourself, either in the tub or shower or by sponge bath, without equipment or adaptive devices.
4. **APPLICANT** means the individual who executed the application for coverage.
5. **ANNIVERSARY DATE** means the renewal date of the policy.
6. **ASSISTANCE** means You require the presence of another human being to ensure that all or part of the Activities of Daily Living may be completed or to ensure your safety.
7. **BODILY INJURY** means identifiable physical injury which:
 - a) is caused by an Accident, and
 - b) solely and independently of any other cause, except Illness directly resulting from, or medical or surgical treatment rendered necessary by such injury, occasions the Disablement of the Insured Person within twelve (12) months from the date of the Accident.
8. **COMPANY** means AmFirst Insurance Company Ltd.
9. **CLAIMS PAID** means the total amount of Claims Paid for a disability as defined in this policy.
10. **CLASS** means characterizations of all policies of the same type, including but not limited to: deductible's, policy origination date, age, group, geographical area, plans, or a combination of the above.
11. **COUNTRY of RESIDENCE** means the de facto Country of Residence of the Insured. The Country of Residence must be declared on the application form. If the Insured changes his Country of Residence, the Insured must immediately notify the Company about the new Country of Residence. Failure to do so may result in the invalidation or termination of coverage.
12. **CURRENCY:** All payments related to this policy are in U.S. Dollars unless otherwise stated.
13. **DE FACTO COUNTRY of RESIDENCE** means the country stated in the application, but if an Insured is present, in another country for one hundred and eighty (180) or more days consecutively, the most recent such country shall become his or her de facto Country of Residence. This policy shall terminate if the de facto Country of Residence of any Insured Person becomes the United States of America, and coverage of any Dependent shall terminate if the de facto Country of Residence of such Dependent becomes the United States.
14. **DEPENDENTS** means the following persons:
 - a. The primary Insured's spouse.
 - b. Any of the following qualify as the primary Insured's Dependent(s):
 1. unmarried children;
 2. unmarried stepchildren;
 3. unmarried adopted children of the primary Insured or the primary Insured's spouse;
 4. or unmarried children for whom the primary Insured or the primary insured's spouse has legal guardianship.

15. **DISABLEMENT/DISABLED/DISABILITY** means Disablement, which entirely prevents the Insured Person from being able to conduct any three (3) of the six (6) **Activities of Daily Living**.
16. **ELIMINATION PERIOD** means a period of consecutive days that an Insured Person is continuously Disabled before any Monthly Disability Benefit is payable. No Monthly Disability Benefit is payable during the Elimination Period. The duration of the Elimination Period is shown in the Schedule of Benefits. The Elimination Period begins on the first day of Disability occurring after the Effective Date of this policy and if the Waiting Period has been satisfied if applicable.
17. **ENTIRE CONTRACT** means the actual document, including the application for coverage, the Policy, Policy Provisions, Policy Definitions, General Conditions, General Exclusions, Specific Exclusions, Certificate of Coverage, Schedule of Benefits, and any Amendments or Endorsements.
18. **EVIDENCE OF INSURABILITY** means the Insured Person must have signed an application regarding their medical history, that includes authorization for the Company to obtain information about the health of the Insured Person.
19. **GRACE PERIOD** means that period of time after the policy has lapsed due to non-payment of premium during which time the Insured may continue coverage upon receipt by the Administrator of payment in full of the premium due. The Company will allow a thirty-day (30) Grace Period for annually and semi-annually paid premiums and ten (10) days for monthly paid premiums.
20. **HAZARDOUS ACTIVITIES OR HAZARDOUS SPORTS** means any activity or sport requiring skill or physical prowess, often of a competitive nature, that exposes the participant to any unavoidable danger or risk with the lack of predictability, even though the danger or risk is often foreseeable. Examples of hazardous activities or sports include but are not limited to: sky diving, mountain climbing, rock climbing, rodeo, bullfighting, any type of aviation sport, caving and pot-holing, rafting or canoeing involving white water rapids in excess of grade 5, parachuting, paragliding, hang-gliding, para-sending, test of velocity, motorcycle racing, motor sports or competition, scuba diving at a depth of more than 30 meters, boxing, jockeying, bungee jumping, polo, participation in any extreme sport or participation in any sport for compensation or as a professional.
21. **ILLNESS** means sickness or disease of the Insured Person which first manifests itself during the period the policy is in force and is responsible for the Disablement of the Insured Person within twelve months (12) after first manifesting itself.
22. **INCURRED CLAIMS** means a claim is considered Incurred when all conditions necessary to receive benefits under the policy have been met by the Insured.
23. **INJURY** means Bodily injury, which is not self inflicted, is caused by an Accident and which occurs after the policy is in force.
24. **INSURED or INSURED PERSON(S)** means the individual for whom an application has been completed or in the case of Dependents, those individuals whose names have been declared on the application form, and for whom commencement of coverage has been confirmed by the Company on the Certificate of Coverage and who have been issued a policy and for whom the premium has been paid.

25. **LUMP SUM DISABILITY BENEFIT** means the amount of benefit paid to the Insured Person following the exhaustion of Monthly Disability Benefits which have been paid to the Insured Person. This benefit is equal to one hundred (100) times the MONTHLY DISABILITY BENEFIT stated on the Certificate of Coverage.
26. **LOSS OF USE** means the total and irrecoverable Loss of Use of a Hand, Foot, Arm or Leg of an Insured person and such loss is considered to be permanent and due to an Accidental Injury. With reference to the Eyes means the irrecoverable loss of an Insured person's sight in both Eyes and such loss is considered to be permanent due to an Accidental injury.
27. **ORIGINAL PREMIUM** means the annualized premium in effect for this policy. Original Premium will not include premium increases or benefit increases that may occur for the policy on or after the effective date. Original Premium will be adjusted for any benefit decreases that may occur for the policy on or after the effective date.
28. **MONTHLY DISABILITY BENEFIT** means the amount of benefit paid monthly to a Disabled Insured Person who has met the Elimination and Waiting Periods and is stated for each Insured Person on the Certificate of Coverage. The maximum number of Monthly Disability Benefits to be paid is thirty-six (36).
29. **MAXIMUM BENEFIT PERIOD** means the longest period for which a Monthly Disability Benefit is payable for any one period of Disability, whether from one or more causes. The Maximum Benefit Period begins at the end of the Elimination Period. No Monthly Disability Benefits are ever payable after the end of The Maximum Benefit Period even if the Insured Person is still Disabled.
30. **PAYMENT DUE DATE** means the day the policy's payment is due, as stated on the Certificate of Coverage.
31. **PHYSICIAN or DOCTOR** means a person who is licensed to practice medicine and surgery as a doctor of medicine while acting within the scope of his or her practice and to the extent that benefits are provided.
32. **POLICY YEAR** means a period of twelve (12) consecutive months beginning on the policy effective date.
33. **PRE-EXISTING CONDITIONS** means any condition or consequence related to a medical condition, which (1) manifests itself prior to the effective date of the policy or its reinstatement, which was diagnosed by a Physician prior to the effective date of the policy or its reinstatement; or (2) for which medical advice or treatment was recommended by or received from a Physician prior to the effective date of the policy; or (3) any obvious symptom which, if presented to a Physician would have resulted in a diagnosis.
- There are two types of Pre-Existing Conditions:
- (a) **DISCLOSED AT THE TIME OF THE APPLICATION:** Disclosed Pre-Existing Conditions, unless specifically excluded by endorsement or an amendment to the policy are covered after twenty-four (24) months of continuous coverage under this policy or the period of time declared on the Schedule of Benefits page of this policy, whichever is longer. (See Specific Policy Exclusion 5.)
- (b) **UN-DISCLOSED AT THE TIME OF APPLICATION:** The Company reserves the right to insure persons considered to be in good health and good moral risk. Un-disclosed Pre-Existing Conditions prevent the Company from making the proper evaluation of the risk. Consequently, non-disclosed Pre-Existing Conditions are not covered and could result in the denial of a medical claim and/or the cancellation or rescinding of this policy. (See Specific Policy Exclusion 6)
34. **TENTH ANNIVERSARY DATE** means the date on which this policy has been in force for ten consecutive years. The Tenth Anniversary Date will be on the same day of the year as the policy effective date.
35. **WAITING PERIOD** means the time beginning at the policy effective date and ending ninety (90) days thereafter. No claim will be paid for Illness, which first manifests itself and causes Disablement of an Insured during this time. (see Specific Exclusion 11)
36. **WE or US** means the Company.
37. **YOU or YOUR** means the Insured, Insured Person or Dependent.

GENERAL CONDITIONS

1. This policy, including the Policy Provisions, Policy Definitions, General Conditions, General Exclusions, Specific Exclusions, Certificate of Coverage, Schedule of Benefits, Amendments or Endorsements, and the written application for coverage make up the Entire Contract and shall be read together as one contract. Any word or expression to which a specific meaning has been attached in any part of this policy shall bear such specific meaning, wherever it may appear.
2. The Insured, including any person to whom this insurance applies, shall at all times take reasonable precautions to prevent accidents, loss or injury.
3. If the circumstances in which the insurance was entered into shall be materially changed, this policy shall be voidable.
4. The due observance and fulfillment of the terms, conditions and limitations of this policy insofar as they relate to anything to be done or complied with by the Insured, and the truth of the statements and answers in the said application, shall be conditions precedent to any liability of the Company to make any payment under this policy.
5. If any claim under this policy shall be in any respect fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on behalf of the Insured under this policy, all benefits thereunder shall be forfeited. If any past or present provider of medical services or medications refuses, is unwilling, is unable, cannot locate or trace an Insured's past medical records, after being presented the Insured's authorization to inspect those records, all benefits under this policy shall be forfeited and the policy shall be voidable. The Company reserves the right to determine whether it has enough information on which it bases the validation of any claim submitted and the burden of providing all medical records to the Company shall be upon the Insured.
6. The policy will become null and void unless the Company is notified of any change in the de facto Country of Residence of the Insured within thirty (30) days of the change. All terms and conditions are subject to revision upon a change in the de facto Country of Residence.
7. The Cash Value Benefit provided by this policy is payable only once during the entire time that the policy is in force.
8. The legal representative of an Insured shall have the right to act for an Insured who is incapacitated or deceased.
9. In the event the Company cancels or otherwise invalidates this policy due to the Insured's failure to disclose past medical history or Pre-Existing Conditions, the Company reserves the right to recover from the Insured all costs and fees incurred in reasonably investigating those matters not fully disclosed. Recovery may be accomplished in any lawful manner including deduction of those costs and fees from any unearned premiums otherwise due the Insured.
10. If an Insured or the Company cancels the policy after it has been issued, the Company will refund the unearned portion of the premium, less policy fees and any policy expenses paid. The unearned portion of the premium is based on the number of months corresponding to the payment mode. Policy expenses include commissions, claims handling and administrative fees.
11. It is a condition of this policy that the Insured must sign and date the Company's medical release form when submitting a claim to the Company for consideration. The medical release form will authorize the Company to obtain medical records from any provider. Failure to do so will result in a forfeiture of all benefits otherwise due under a claim submitted by an Insured.
12. Any Insured covered under this policy cannot collect benefits from both the Monthly Disability Benefit and/or the Monthly Loss of Use Benefit, these benefits are **NOT** cumulative. The maximum monthly benefit payable under this policy is the amount stated on the Certificate of Coverage. (Example: If an Insured selected a US\$7,000 Monthly Disability Benefit, the Accidental Monthly Loss of Use Benefit will be limited to US\$5,000. If an Insured suffered an Accident and lost the use of his legs he would qualify for the Monthly Disability Benefit and therefore would receive US\$7,000 per month after satisfying the Elimination Period. However, if the Insured lost the use of one hand he would not qualify for the Monthly Disability Benefit and therefore would receive the Monthly Loss of Use Benefit of US\$5,000 per month after satisfying the Elimination Period.
13. Benefits payable pursuant to the terms and conditions of this policy shall cease upon the death of the insured, which, for the purposes of this policy, shall be defined as the time at which irreversible cessation of that person's brain function occurs.

GENERAL EXCLUSIONS

The Company shall not be liable for any claim or benefit or any consequence whether directly or indirectly, proximately or remotely, occasioned by, contributed to, by or traceable to, or arising in connection with:

- (I) War, invasion, act of foreign enemy, hostilities or warlike operations (whether war is declared or not) or civil war.
- (II) Mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power.
- (III) Any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the government de jure or de facto or to the influencing of it by terrorism or violence.
- (IV) Martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrence").
- (V) Committing or attempting to commit a criminal offense, or provoking an assault.
- (VI) Any act of terrorism.
- (VII) Any radioactive contamination.
- (VIII) Nuclear/Chemical/Biological Terrorism in any way caused or contributed to by an act of war or terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.

The Company and the Insured agrees that regardless of any contributory cause(s) this insurance does not cover any claim(s) in any way caused or contributed to by an act of war or terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.

For the purpose of these exclusions an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put, or any section of the public at fear.

Any consequent happening or arising during the existence of abnormal conditions (whether physical or otherwise) whether directly or indirectly, proximately or remotely, occasioned by or contributed to, traceable to or arising in connection with any of the said occurrences shall be deemed to be a consequence for which the Company shall not be liable under this policy except to the extent that the Insured shall prove that such consequence happened independently of the existence of such abnormal conditions.

In any action, suit or other proceeding where the Company alleged that by reason of these exclusions any consequence is not covered by the policy, the burden of proving that such consequence is covered shall be upon the Insured.

SPECIFIC EXCLUSIONS

Any claim or benefit related to the following or the consequences thereof are not covered under this policy:

1. Treatment of mental illnesses, dementia, Alzheimer's disease, psychiatric, psychological or behavioral disorders and maintenance in a mental facility.
2. All Hazardous Activities and Hazardous Sports. This does not include normal vacation sports such as skiing or snorkeling. However, based on the "Prudent Man Rule", the Company will deny claims when it is determined that risk or negligence was a factor. Other sports will also be excluded where they involve a higher risk due to inexperience, lack of care, or knowledge of overly dangerous conditions.
3. Bodily injury sustained while under the influence of or Disablement due wholly or partly to the effects of intoxicating liquor or drugs or with a blood alcohol level of 100mg percent or more, other than taken in accordance with treatment prescribed by a physician or the Insured Person being diagnosed as alcoholic.
4. Claim related to a willfully self-inflicted injury or suicide.
5. Any disclosed Pre-Existing Condition, physical defect, infirmity, medical condition, or chronic or recurring illness which existed at or within two (2) years of the date of entry of an Insured Person into this insurance.
6. Any claim relating to undisclosed Pre-Existing Conditions are not covered for the life of this policy.
7. Any claim arising directly or indirectly from any death, Bodily Injury, Illness, expense or other liability attributable to Human Immunodeficiency Virus (HIV) and/or HIV illness including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutant derivative or variations thereof, however caused.
8. Any claims after the expiration date of the policy, resulting from any Accident or Illness which occurred during the policy period.
9. Any claim arising from the Insured's treatment of any Bodily Injury or Illness for which the person for whom the claim is being presented is not under the regular care of a Physician or which are not authorized or prescribed by a Physician.
10. An Insured being treated or under the care of a family member.
11. Any Illness which first manifests itself during the first ninety (90) days after the inclusion of any Insured Person into this insurance are not covered for the life of the policy.
12. The Insured Person engaging in Air Travel except as a passenger in a multi-engine fixed-wing aircraft.
13. Any claim related to any Illness, Accident, Bodily Injury, or the inability to perform three (3) of the six (6) Activities of Daily Living caused by or contributed to being overweight or the condition known as obesity.
14. The Insured engaging in or taking part in armed forces services or operations.
15. Any claim that is not advised to the Company within twenty-one (21) days from the onset of Disablement.
16. Any dispute, claim or controversy which the Insured has not filed a request for arbitration within one-hundred and eighty (180) days from the date of the event which caused the dispute, claim or controversy.
17. Any claim for benefits, (either Monthly Disability Benefits or Lump Sum Benefits), after the anniversary date of the policy following the Insured's 65th birthday.
18. Illnesses and disease as a result of alcoholism, drug abuse or addiction to any substance, however caused and consequences or variations thereof.

In the event of an Insured Person becomes Disabled, notification must be given to Morgan-White Administrators International's office within 21 days.

FOR CLAIMS INFORMATION: Write, call, fax or email

**Morgan-White Administrators International, Inc.
3191 Coral Way, Suite 704
Miami, Fl. 33145**

Telephone: (305) 442-0899

Fax: (305) 442-0961

Email: intlclaims@morganwhite.com

NUMBERS FOR WEEKENDS, HOLIDAYS OR IF OUT OF U.S.A. CALL:

Morgan-White Administrators International, Inc.

Monday-Friday 8:30 a.m. to 5:00 p.m Eastern U.S.Time

Telephone: (305) 442-0899

For After Hours and on Weekends Call:

Telephone: (305) 476-0022

Fax (305) 442-0961