

Florida Gulf Coast University

Voluntary Accidental Death & Dismemberment Insurance
GTU 5091800

The following is a brief description of the Voluntary Accidental Death and Dismemberment Plan. The benefits described are subject to certain limitations and exclusions as described in the Policy. For specific definitions of terms used below as well as further details and information about this Plan, please see the Policy.

Eligibility

Class I: All active, full-time Employees of the Policyholder, working a minimum of 30 hours per week, domiciled in the United States.

You may elect to include coverage for your eligible dependents under the Family Plan. Eligible dependents include your legally married Spouse and your unmarried dependent children from birth to 19 years of age, or to age 25 if attending an accredited school or college on a full-time basis, and are primarily dependent upon you for their support and maintenance.

No individual may be covered more than once under this Plan. You cannot be covered as a Spouse or dependent child of another employee.

Benefit Amount

Class I: An employee may purchase an amount of Principal Sum from a minimum of \$10,000 to a maximum of \$350,000 in increments of \$10,000. However, amounts applied for in excess of \$150,000 must not exceed ten (10) times the employee's base annual earnings*.

* Base annual earnings means the employee's base annual pay excluding overtime, bonuses, commissions and special compensation.

The Benefit Amount for your Covered Dependents will be a percentage of your Benefit Amount, as follows:

<u>Plan Selected</u>	<u>% Spouse</u>	<u>% Child(ren)</u>
Spouse only:	55%	0
Dependent Child(ren) only:	0	15%
Spouse and Dependent Child(ren)	45%	10%

Maximum of \$25,000 **Principal Sum** for **Dependent Child(ren)**

At age 70, for the Insured Employee only, your Benefit Amount will be reduced based on your previous Benefit Amount per the following schedule:

<u>Age at Date of Loss</u>	<u>Percent of Principal Sum</u>
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

Description of Coverage

This plan offers protection on a worldwide basis, 24 hours a day, 365 days a year against certain injuries resulting from a covered accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile, or other public and private conveyances, subject to certain limitations (see exclusions/limitations). The benefits provided are payable in addition to any other insurance which may be in effect at the time of the accident.

Exposure and Disappearance Coverage

If the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event, We will presume that you lost your life as a result of Injury. If travel in such conveyance was covered under the terms of the Policy, We will pay your Benefit Amount, subject to all Policy terms.

If you are exposed to weather because of an accident and this results in a loss of life, We will pay your Benefit Amount, subject to all Policy terms and conditions.

Benefits Provided

If you have an accident that results in any of the following losses, We will pay the benefit shown within 365 days of the date of the accident, Zurich American Insurance Company, may pay certain Benefit Amounts to you or your designated beneficiary. If the accident results in more than one of these losses, only the loss with the largest benefit will be payable. The amounts are based on the Benefit Amount shown in the Schedule.

Loss of:	Benefit Amount
(1) Life	100% of Benefit Amount
(2) Both hands or both feet	100% of Benefit Amount
(3) One hand and one foot	100% of Benefit Amount
(4) One hand or one foot plus the sight of one eye	100% of Benefit Amount
(5) Sight of both eyes	100% of Benefit Amount
(6) Speech and Hearing	100% of Benefit Amount
(7) Speech or Hearing	50% of Benefit Amount
(8) One hand, one foot, or sight of one eye	50% of Benefit Amount
(9) Thumb and index finger of the same hand	25% of Benefit Amount
Plegia	Benefit
(1) Quadriplegia (total paralysis of all four Limbs)	100% of Benefit Amount
(2) Paraplegia (total paralysis of both lower Limbs)	75% of Benefit Amount
(3) Hemiplegia (total paralysis of upper and lower Limbs on one side of the body)	50% of Benefit Amount

Additional Benefits through the Plan

Common Carrier Benefit

If you or your Covered Spouse suffer a covered loss of life, we may pay an additional benefit of two times the Principal Sum to a maximum of \$100,000 if the loss occurred while riding as a passenger on a common carrier.

Felonious Assault Benefit:

If you sustain a covered loss of life as a result of a violent or criminal act committed by someone other than you or a member of your family, incurred in connection with the Policyholder's normal business whether on or off the Policyholder's premises and the crime directly involves the Policyholder's funds or assets, an additional 10% of your Benefit Amount may be paid to a maximum of \$10,000.

Higher Education Benefit

If you elect Family Plan Coverage and suffer a covered loss of life, and have an eligible Covered Child(ren), who on the date of the accident, is enrolled as a full-time student in an institution of higher learning or is at the 12th grade level and enrolls in an institution of higher learning within one year from the date of the accident, an additional benefit of 5% of your Benefit Amount to \$5,000 per year may be paid for each such Covered Child for up to four (4) consecutive years.

Seat Belt/Air Bag Benefit

If a Covered Person suffers a covered loss of life in a covered automobile accident while wearing a factory installed or manufacturer authorized seat belt or lap and shoulder restraint, an additional 10% of the Benefit Amount to a maximum of \$25,000 may be paid. An additional benefit equal to \$5,000 may be paid if the Covered Person was driving or riding in a private passenger automobile with a manufacturer equipped air bag.

Survivor's Benefit

If you elect Family Plan Coverage and you or your Covered Spouse suffer a covered loss of life, an

additional monthly benefit may be paid over a period of 6 months equal to 3% of your Benefit Amount.

Travel Assistance Coverage

A comprehensive travel assistance program offering you benefits and services when traveling 100 miles or more from your residence. You can access Zurich Travel Assist[®] services by calling, toll-free, 1-800-263-0261 and referencing Policy number GTU 5091800 or logging on to their web site at www.zurichna.com/travelassist. Services provided include Medical, Informational, Legal, and Personal Assistance.

Beneficiary Designation

Benefits for your loss of life will be payable to the beneficiary or beneficiaries designated in writing by you and on file with the Policyholder; otherwise We will pay the benefit to the Insured's survivors in the following order:

1. Your Spouse;
2. Your Children, equally;
3. Your Parents, equally or to the survivor;
4. Your Brothers or Sisters equally or to the survivor or survivors;
5. Your Estate.

Loss of Life of a Covered Person other than You:

Covered Losses for the death of a Covered Person other than you will be paid to you. If you pre-decease or die at the same time as the Covered Person other than you, the benefit will be paid to your beneficiary unless your beneficiary designation has not been made or your beneficiary is no longer living at the time of death. In such case, the benefits will be paid to your estate.

All other indemnities shall be payable to you.

To File a Claim

Contact Zurich American Insurance Company at 1-866-841-4771 for a claim form. Complete the form and send it to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041 within 90 days of the loss. Refer to Plan Number GTU 5091800.

Important

This is a brief description of the coverage provided through the Voluntary Accidental Death & Dismemberment plan. If any conflict should arise between the contents of this handout and the Master Policy or if any point is not covered herein, the terms of the Master Policy shall govern in all cases.

Exclusions

This plan does not cover any loss caused by, contributed to or resulting from: suicide or attempted suicide while sane; a purposefully self-inflicted wound; war or any, act of war, declared or undeclared; a Covered Person's involvement in any type of active military service; illness, disease or infection, other than infection occurring in an external accidental wound, pregnancy, including childbirth or complications thereof; skydiving, parasailing, hang gliding, bungee-jumping, or any similar activity; or the Insured's participation in the commission or attempted commission of any felony; flying as a pilot or crew member of any aircraft except for pilots on file with the Policyholder; any aircraft being used for aerial photography, test or experimental purposes; any aircraft that requires a special permit or waiver even if granted; any aircraft owned or controlled by, or under lease to the Policyholder, an Insured, or a member of a Covered Person's family or household; any aircraft which is operated by the Policyholder, or one of its employees including members of an employee's family or household; any conveyance used in a race or speed test or being used for tests or experimental purposes.

Cost and Method of Payment

The monthly cost for Employee Only Coverage is \$.035 for each \$1,000 of Benefit Amount. The monthly cost for the Family Plan is \$.055 for each \$1,000 of Benefit Amount. Premium payments will be deducted automatically from your pay. Premium payments will be deducted automatically from your pay.

ZURICH AMERICAN INSURANCE COMPANY

VOLUNTARY AD&D ENROLLMENT FORM

Employer: _____ Group Policy No. _____

Employee: _____ SSN: _____
(Last Name, First Name, Middle Initial)

Address: _____
(Street and Number) (City, State, Zip)

Date of Birth: ____ / ____ / ____ Sex: [] Male [] Female

Department: _____ Occupation: _____

Office Address: _____ Annual Salary: \$ _____

Plan Choice: (check one of the plans below)

- [] Plan I-Employee Only
[] Plan II-Employee and Family

Amount of Insurance: \$ _____ Monthly Premium: \$ _____

If you have selected Employee and Family coverage, Spouse Name: _____
(Last Name, First Name, Middle Initial)

Primary Beneficiary: _____ Relationship: _____

Contingent Beneficiary: _____ Relationship: _____

As an employee of the University, I work _____ hours per week.
I am employed on a _____ month contract.

Date Employed: ____ / ____ / ____ Policy Effective Date: ____ / ____ / ____

Date of Application: ____ / ____ / ____ X _____
(Signature of Applicant)

Agent _____

Payroll Deduction Agreement

I hereby request and authorize my employer to deduct the appropriate premium from my salary when I become eligible for this insurance and for each period thereafter, automatically including future rate increases, and to calculate into deduction modes consistent with the payroll system of my employer, including prorated or accelerated deductions, as applicable. The deductions are to be continued until:

- (a) I request that this authorization be cancelled, or (b) Termination of my employment

The amounts so deducted are to be paid to The Gabor Agency, Inc., Tallahassee, Florida, on behalf of Zurich American Insurance Company to cover premiums on AD&D insurance applied for by me.

Date _____ Signature of Applicant _____