



Chubb Policy

9907-37-18

7-1-15 to 7-1-16

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Special Risk  
INSURANCE PROGRAM  
Issued by  
FEDERAL INSURANCE COMPANY  
FOR  
CITY OF MEDFORD

The **Policyholder** has the right to return this policy within ten (10) days of receipt. If the **Policyholder** returns the Policy to **Us** or **Our** agent at the address below, **We** will consider the Policy void and **We** will refund any premium.

Chubb Underwriting Office: FEDERAL INSURANCE COMPANY  
Suite 4700  
233 South Wacker Drive  
Chicago, IL 60606-6303

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*Words and phrases that appear in **bold print** have special meaning and are defined in the Definitions section(s) of this policy. Defined terms include the plural.*

*Throughout this policy the words "**We**", "**Us**" and "**Our**" refer to the **Company** providing this insurance.*

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**Please Read This Policy Carefully**

BTA5000OR-A (Ed 3/2007)

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## Insuring Agreement

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### Section I

*Chubb Group of Insurance Companies  
15 Mountain View Road, P.O. Box 1615  
Warren, New Jersey 07061-1615*

**Policyholder's Name and Address:**

CITY OF MEDFORD  
411 WEST 8TH STREET  
MEDFORD, OR 97501  
Policy Number: 9907-37-18  
Effective Date: 07/01/2015  
Anniversary Date: July 1

*Issued by the stock insurance company  
indicated below:*

**FEDERAL INSURANCE COMPANY**  
*Incorporated under the laws of  
INDIANA*

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### Section II Policy Period and Company

#### Policy Period

From: 05/20/2015 To: 07/01/2016  
12:01 A.M. standard time at the **Policyholder's** address shown in Section I of the Insuring Agreement.

This insurance is provided by the **Company** in consideration of payment of the required premium.

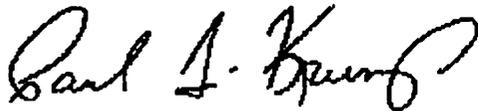
The insurance under this policy begins on the Effective Date shown in Section I of the Insuring Agreement. The insurance under this policy ends on the last day of the Policy Period shown in Section II of the Insuring Agreement.

The **Policyholder's** acceptance of this policy terminates any prior policy of the same policy number, effective with the inception of this policy.

#### Company

The **Company** issuing this policy has caused this policy to be signed by its authorized officers, but this policy shall not be valid unless also signed by a duly authorized representative of the **Company**.

**FEDERAL INSURANCE COMPANY** (Incorporated under the laws of INDIANA)



President



Secretary



Authorized Representative

## Premium Summary

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### Section I - Premium Due Date

07/01/2015

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### Section II - Premium Payment

The **Policyholder** shown in Section I of the Insuring Agreement is responsible for the collection and remittance of all required premiums. Premiums are calculated and payable as follows:

Special Risk

Amount Due:

\$738

Any premiums shown as subject to adjustment will be adjusted as stated in the Premium Provisions under Section VIII - General Provisions of the Contract.

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## Schedule of Benefits

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*Chubb Group of Insurance Companies  
15 Mountain View Road, P.O. Box 1615  
Warren, New Jersey 07061-1615*

**Policyholder's Name:**  
CITY OF MEDFORD

*Issued by the stock insurance company  
indicated below:*  
**FEDERAL INSURANCE COMPANY**  
*Incorporated under the laws of  
INDIANA*

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### Section I - Insured Persons

The following are the **Insured Persons** under this policy:

<b>Class</b>	<b>Description</b>
1	All registered volunteers of the Policyholder.
2	All registered volunteers of the Policyholder's Community Emergency Response Team (CERT)

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If, subject to all the terms and conditions of this policy a person is eligible for insurance under multiple **Classes of Insured Persons** described above, then such person will only be insured under the **Class** which provides the **Insured Person** the largest **Benefit Amount** for the loss that has occurred.

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### Section II - Qualification Period

For **Insured Persons** in an eligible **Class** on the Effective Date: none  
For **Insured Persons** entering an eligible **Class** after the Effective Date: none

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### Section III - Hazards

The following are the **Hazards** for which insurance applies:

<b>Class</b>	<b>Hazard(s)</b>
1	<b>Volunteer Duties</b>
2	<b>Volunteer Duties</b>

If, subject to all the terms and conditions of this policy an **Insured Person** has insurance for covered loss on the date of an **Accident**, covered under multiple **Hazards** described above, then only one **Benefit Amount** will be paid. This **Benefit Amount** shall be the largest **Benefit Amount** applicable under all such **Hazards**.

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## **Section IV - Benefits**

### **A) Principal Sum**

The following are **Principal Sums** for each **Class**:

<b>Class</b>	<b>Hazard</b>	<b>Principal Sum</b>
1	Volunteer Duties	\$20,000
2	Volunteer Duties	\$20,000

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**B) Accidental Death and Dismemberment Benefits:**

This benefit applies to all **Classes of Insured Persons**. The following are **Losses** insured and the corresponding **Benefit Amount** expressed as a percentage of the **Principal Sum**:

**Class(es)**

All

<b>Accidental:</b>	<b>Benefit Amounts (Percentage of Principal Sum)</b>
<b>Loss of Life</b>	100%
<b>Loss of Speech and Loss of Hearing</b>	100%
<b>Loss of Speech and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye</b>	100%
<b>Loss of Hearing and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye</b>	100%
<b>Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye</b>	100%
<b>Quadriplegia</b>	100%
<b>Paraplegia</b>	75%
<b>Hemiplegia</b>	50%
<b>Loss of Hand, Loss of Foot or Loss of Sight of One Eye (Any one of each)</b>	50%
<b>Loss of Speech or Loss of Hearing</b>	50%
<b>Uniplegia</b>	25%
<b>Loss of Thumb and Index Finger of the same hand</b>	25%

This **Benefit Amount** is subject to Section IV - Maximum Payment for Multiple Losses and Multiple Benefits, of the Contract.

If an **Insured Person** has multiple **Losses** as the result of one **Accident**, then **We** will pay only the single largest **Benefit Amount** applicable to the **Losses** suffered, as described in Section IV - Maximum Payment For Multiple Losses and Multiple Benefits of the Contract.

**C) Additional Benefits**

The following are **Benefit Amounts** for all other benefits provided under this policy:

**Excess Accident Medical Expense**

**Class 1**

- Benefit Amount \$50,000**
- Deductible \$0**
- Dental Benefit Amount \$50,000**
- Physical Therapy Benefit Amount \$50,000**
- Orthopedic Appliance Amount \$50,000**

**Class 2**

- Benefit Amount \$50,000**
- Deductible \$0**
- Dental Benefit Amount \$50,000**
- Physical Therapy Benefit Amount \$50,000**
- Orthopedic Appliance Amount \$50,000**

The **Benefit Amounts** shown above for Dental, Physical Therapy and Orthopedic Appliance are part of, and not in addition to, the **Benefit Amount** for **Excess Accident Medical Expense**. Payment of these **Benefit Amounts** reduces and does not increase the **Benefit Amount** for **Excess Accident Medical Expense**. This **Benefit Amount** is not subject to Section IV - Maximum Payment for Multiple Losses and Multiple Benefits, of the Contract.

## **Section V - Aggregate Limit of Insurance**

**\$250,000 per Accident**

If more than one (1) **Insured Person** suffers a **Loss** in the same **Accident**, then **We** will not pay more than the **Aggregate Limit of Insurance** shown above. If an **Accident** results in **Benefit Amounts** becoming payable, which when totaled, exceed the applicable **Aggregate Limit of Insurance** shown above, then the **Aggregate Limit of Insurance** will be divided proportionally among the **Insured Persons**, based on each applicable **Benefit Amount**.

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Insurance only applies for the **Classes, Hazards, Benefits and Losses** that are specifically indicated as insured.

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## Hazards

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### Volunteer Duties Hazard

**Volunteer Duties Hazard** means all circumstances, subject to the terms and conditions of this policy, arising from and occurring while a **Primary Insured Person** is:

- 1) participating in volunteer duties pursuant to a formal program supervised by the **Policyholder** whether on or off premises.
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## How to file a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.  
Please forward claims and questions to the following address:

Administrative Concepts, Inc  
994 Old Eagle School Road  
Suite 1005  
Wayne, PA 19087-1082  
888-293-9229  
Fax: 610-293-9299  
[www.visit-aci.com](http://www.visit-aci.com)

**Step 1: Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

**The Participating Organization (not the Parent, Claimant or Agent) should:**

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

**Step 2: Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

### Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an Insurance company is not an admission of coverage
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges).
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.



**CHUBB GROUP**  
**OF INSURANCE COMPANIES**

**Administrative Concepts, Inc.**

994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802  
Phone: 888-293-9229 Fax: 610-293-9299  
Web: www.visit-aci.com



1. PLEASE FULLY COMPLETE FORM
2. ATTACH ITEMIZED BILLS AND EOBs
3. MAIL TO ADMINISTRATIVE CONCEPTS INC.

**Policy Number:** \_\_\_\_\_  
**Policy Holder:** \_\_\_\_\_

**PART I - POLICYHOLDER'S REPORT**

1. Claimant's Name (Injured person)		2. Social Security Number	3. Gender	4. Date of Birth	5. Primary Parent E-Mail
6. Father's Name, Address and Best Contact Phone Number (Include Area Code)					
7. Mother's Name, Address, and Best Contact Phone Number (Include Area Code)					
8. Date and Time of Accident	9. Place where Accident Occurred		10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other <input type="checkbox"/> Volunteer		
11. Specify the Covered Class for the Injured person if applicable:					
Dental Claims	12. Indicate which Teeth were Involved in the Accident		13. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
14. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.)					
15. Describe How Accident Occurred - Give All Possible Details - Must be a Bodily Injury Due to Accident					
16. Has the claimant suffered from the same or similar condition before?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17. Did Accident Occur (Check Yes or No for Each of the Following):					
A. During a policyholder program, sponsored & supervised, or sanctioned activity?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
B. On activity premises?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
C. While traveling directly and uninterruptedly to or from home and school?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
D. During the participation of an interscholastic athletic practice or competition?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18. Name of Event or Activity			19. Name of Event or Activity supervisor		
20. Signature of School Official			21. Name and Title of School Official		22. Date

**PART II - OTHER INSURANCE STATEMENT**

Are you entitled to benefits under any other insurance policy covering this injury?  YES  NO  
If NO, please complete the "CERTIFICATION OF NO OTHER INSURANCE" portion on this form.  
If YES, please attach copies of statements of benefits paid or denied and complete the following:

Are you eligible to receive benefits under any governmental plan or program, including Medicare?  YES  NO  
If yes, Please explain:

Name & Address of Insurance Company	Policy #
Name of insured person carrying other coverage	Name of Employer providing other coverage

**CERTIFICATION OF NO OTHER INSURANCE**

I, \_\_\_\_\_, hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

Signature of Claimant or Authorized Representative	Dated
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*Administrative Concepts, Inc. does not share Private Health Information except as required or permitted by law.  
We are committed to guarding the Private Information entrusted to us.*

**PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.**

**BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF**

**AUTHORIZATION and ASSIGNMENT OF BENEFITS**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signature of Claimant or Authorized Representative	Dated
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*The laws of some states require us to furnish you with the following notices:*

**WARNING. Any person who knowingly:**

**Alaska:** and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona, Arkansas and Rhode Island:** presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR and RI:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form:  
Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Delaware:** and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Idaho and Indiana:** and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

**Kentucky, New York and Pennsylvania:** and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Louisiana, New Mexico, Texas and West Virginia:** presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

**Maryland:** and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio:** with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

**Puerto Rico:** and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**WARNING:**

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Hawaii:** Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Maine/Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**Tennessee and Virginia :** It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.