GROUP BUSINESS TRAVEL ACCIDENT SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES OF INTACT SERVICES USA LLC

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: **Intact Services USA LLC**

POLICY NUMBER: **212-000-015**

COVERED SUBSIDIARIES OR AFFILIATED COMPANIES:

Atlantic Specialty Insurance Company
A.W.G. Dewar, Inc.
Intact Insurance Group USA LLC
International Bond & Marine
The Guarantee Company of North America

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

CERTIFICATE OF INSURANCE

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SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

PRIMARY INSURED PERSON - CERTIFICATE HOLDER.

Class	Description
1	All **Active** employees of the **Policyholder**

If **You** sustain an **Injury** resulting in a **Covered Loss**, and **You** are covered under more than one Class, only one benefit will be paid, the largest benefit.

Effective Date. A. If **You** are hired prior to January 1, 2008:
Your first day of **Active** work following the effective date of the **Policy**

B. If **You** are hired on or after January 1, 2008:
Your first day of **Active** work following **Your** date of hire

If **You** are not **Actively at Work** on **Your** Effective Date of coverage, coverage will begin on **Your** first full day of **Active** work following **Your** Effective Date.

Termination Date. Your coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for coverage;
3. **You** fail to pay the required premium, if **You** are so required; or
4. **You** retire.

SECTION II – SCHEDULE

HAZARDS

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

Class I	24 Hour **Accident** Protection, While on a Business Trip, Excluding Corporate **Owned** or **Leased** Aircraft

Additional Coverages

Class 1	Exposure and Disappearance Coverage Family Traveling with Employee on Business and/or Relocation Trips Coverage

BENEFITS

A. Principal Sum

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

Class 1	Five (5) times the employee's **Base Annual Earnings*** rounded up to the next highest $1,000, to a maximum of $1,750,000

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

Principal Sum Reduction

At age 70, **Your Principal Sum** will be reduced based on **Your** previous **Principal Sum** on the January 1st after **Your** attainment of the ages specified below:

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

Aggregate Limit of Liability

The **Aggregate Limit of Liability** per **Covered Accident** is $7,500,000.

B. Accidental Death Benefit

This benefit applies to Class 1.

C. Accidental Dismemberment and Covered Loss of Use Benefit

This benefit applies to Class 1.

D. Coma Benefit

This benefit applies to Class 1.

E. Additional Benefits

Class 1 Seat Belt Benefit

Travel Assistance Benefit

SECTION III – HAZARDS

24 HOUR ACCIDENT PROTECTION WHILE ON BUSINESS TRIP, EXLUDING CORPORATE OWNED OR LEASED AIRCRAFT

The **Policy** insures against the following **Hazards:**

A **Covered Injury** sustained by **You** anywhere in the world while on the **Business of the Policyholder**, subject to the terms, conditions, limitations and exclusions under the **Policy**.

Coverage, subject to limitations and exclusions, is provided between:

1. the later of the time **You** leave the place where **You** normally work or live; and
2. the earlier of the time **You** return to the place where **You** normally work or live.

Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while **You** are a passenger, riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

1. If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft.
2. For an assignment by the **Policyholder** or relocation that exceeds sixty (60) days in duration. Note: If an assignment exceeds sixty (60) days in duration, the location of the assignment will be considered the place of permanent assignment, and **You** will then have **Coverage** when traveling elsewhere on the **Business of the Policyholder**.
3. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. any aircraft other than those expressly stated in this **Hazard**;
   b. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**.
   c. any aircraft **Owned** or **Controlled** by, or **Under lease** to a **Primary Insured Person** or a member of a **Primary Insured Person's** family or household;
   d. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
   e. any aircraft engaged in a **Specialized Aviation Activity**;
   f. any conveyance used for tests or experimental purposes, or in a race or speed test.

Hazard Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation. It does include **Personal Deviations/Side Trips**.
- **Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; 3) is taken during the course of the business trip; and 4) is limited to 72 hours.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

SECTION IV – ADDITIONAL COVERAGES

EXPOSURE AND DISAPPEARANCE COVERAGE

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

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 this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that [**You**] [the **Insured Person**] survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

FAMILY TRAVELING WITH EMPLOYEE ON BUSINESS AND/OR RELOCATION TRIPS COVERAGE

Your Spouse and/or **Dependent Child(ren)** will also be considered a **Primary Insured Person** when they are traveling on a business and/or relocation trip with **You** that is approved by and at the expense of the **Policyholder**. Their coverage will be limited to the **Accidental Death Benefit** and the **Accidental Dismemberment and Covered Loss of Use Benefit** as stated in the **Policy**, when the eligibility for such **Benefit** results from the **Hazards** covered by the **Policy**.

This **Coverage** for **Your Spouse** and/or **Dependent Child(ren)** ends upon arrival at the destination of the **Policyholder's** last reimbursed trip.

The **Principal Sum** for **Your Spouse** and each **Dependent Child** will be as follows:

Spouse: $50,000

Dependent Child(ren): $25,000

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if **You** sustain a loss of life as a result of a **Covered Injury**, and the death occurs within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VII Limitations.

ACCIDENTAL DISMEMBERMENT AND LOSS OF USE BENEFIT

We will pay the benefit amount shown below, if an **Injury** to **You** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**
• Both Hands or Both Feet	**Principal Sum**
• One Hand and One Foot	**Principal Sum**
• One Hand or One Foot plus the loss of Sight of One Eye	**Principal Sum**
• Sight of Both Eyes	**Principal Sum**
• Speech and Hearing	**Principal Sum**
• Speech or Hearing	50% of **Principal Sum**
• One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
• Thumb and Index Finger of the same Hand	25% of **Principal Sum**

Covered Loss of Use of	**Benefit**
• Both Arms and Both Legs	**Principal Sum**
• Both Arms or Both Legs or a Combination of an Arm and a Leg	75% of **Principal Sum**
• One Arm or One Leg	50% of **Principal Sum**
• Both Hands or Both Feet or a Combination of a Hand and a Foot	50% of **Principal Sum**
• One Hand or One Foot	25% of **Principal Sum**

A reduced benefit will be payable equal to 50% of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after 365 days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;

d. Total and permanent loss of speech;

e. Total and permanent loss of hearing.

- **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible.

This benefit is subject to the limitations in Section VII Limitations.

COMA BENEFIT

We will pay a **Coma Benefit,** if **You** sustain an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days.

The **Coma Benefit** is equal to 1% of **Your Principal Sum**, and will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. **You** are no longer in a **Coma** which directly resulted from the **Injury**;

2. **You** have received a **Coma Benefit** for 100 months.

Brief periods of consciousness of no more than one (1) day in duration will not effect **Your** eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VII Limitations.

SECTION VI – ADDITIONAL BENEFITS

SEAT BELT BENEFIT

We will pay an additional benefit equal to 10% of the applicable **Principal Sum** up to a maximum of $25,000, if **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that **You** were:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and

2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of **Your** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or

2. by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt Benefit** if **You** are the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and are either:

1. under the influence of alcohol;

a. **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.

b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,

2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.

TRAVEL ASSISTANCE

Travel Assistance will be available to the following **Insured Persons** when they are traveling 100 miles or more from their **Principal Residence**: **You** and **Your Spouse** and/or **Child(ren)**, if **Your Spouse** and/or **Child(ren)** are with **You**

while **You** are covered under the **Policy**. **Your Spouse** or **Child(ren)** will not be covered while making a trip without **You**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation
  If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

  For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

  Assisted Repatriation
  If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence,** or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

  Post-Recovery Repatriation
  If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion.

  Return of Remains
  If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

  Visit to Hospital
  If an **Insured Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

  Return of Child
  If an **Insured Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Insured Person,** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person,** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion
If an **Insured Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VIII General Exclusions of this **Certificate**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person**.

Western Medical Standards means generally accepted medical standards comparable to those in the United States, or Canada or Western Europe.

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy,** the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery
We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.

Reservation of Rights
We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services.

Scope
Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance,** and in no way supersedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call 1-866-670-6693 from the U.S. or Canada; and collect from anywhere else in the world at +1-973-630-6693.

SECTION VII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if **You** sustain more than one loss as a result of the same **Accident.**

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is **Your Principal Sum,** if **You** can recover benefits under more than one of these: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit,** and **Coma Benefit** as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit, if **You** sustain a **Covered Loss** that is covered under more than one **Hazard**.

Aggregate Limit.

We will not pay more than the **Aggregate Limit of Liability** stated in the Schedule.

SECTION VIII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
- war or any act of war, whether declared or undeclared;
- involvement in any type of active military service. (For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service.);
- illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in any aircraft except to the extent stated in the **Hazards** Section.

SECTION IX – CLAIMS PROVISIONS

Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name **You**, the **Insured Person** who sustained the **Injury**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-583-2233. The notice must be sent to the Claims Department, OneBeacon America Insurance Company, 44 Whippany Road, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss,** and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
   a. **Your Spouse**;
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e. **Your** estate.
2. All Other Claims. Benefits are to be paid to **You**.

Physical Examination and Autopsy. We have the right to examine [**You**] [the **Insured Person**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. You have the sole right to choose his or her duly licensed **Physician** and hospital.

Right to Recover Overpayments. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

SECTION X – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us.**

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your Coverage**, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Assignment of Interest. A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

SECTION XI – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy.** For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause occurring within a one (1) day period and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- **Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.
- **Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

- **Coverage(s)** means the event or events described in the **Hazards** Section and Additional Coverages Section of this **Certificate** to which benefits and additional benefits apply. The **Hazards** and Additional Coverages are listed in the Schedule.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under this **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under the **Policy**.
- **Dependent** means **Your Spouse** and **Dependent Child(ren),** as defined in this Section.
- **Dependent Child(ren)**, if used in this **Certificate**, means **Your** unmarried **Child(ren)**, and those unmarried **Child(ren)** of **Your Spouse** who rely on **You** for more than 50% of their support, through the end of the month in which such Child(ren) has attained age 26 (twenty-six), or who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- **Injured, Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of the **Policy**. It includes **You**.
- **Owned Aircraft** means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule**.**
- **Policy** means the Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Primary Insured Person** means an individual who has an employment relationship with the **Policyholder** and is eligible for coverage under the **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I. The **Primary Insured Person** is the Certificate Holder.
- **Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

  acrobatic or stunt flying
  aerial photography
  banner towing
  bird or fowl herding
  crop dusting
  crop seeding
  crop spraying
  endurance tests
  exploration
  fire fighting
  hanggliding
  hunting
  parachuting or skydiving
  pipe line inspection
  power line inspection
  racing
  skywriting
  test or experimental purpose
  flight on a rocket-propelled or rocket launched aircraft
  flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted;
- **Spouse**, if used in the **Policy**, means **Your** legally married **Spouse**.
- **Under lease**, as used in the **Hazards** Section**,** means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

- **We, Us** and **Our** refers to OneBeacon America Insurance Company.
- **You** and **Your** refers to the **Primary Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested, and, if required by state law, the Policy shall not be valid unless countersigned by Our authorized representative.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Michael Miller, President & CEO
OneBeacon America Insurance Company

ONEBEACON AMERICA INSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

CERTIFICATE OF ASSUMPTION

EFFECTIVE OCTOBER 1, 2012

Policy #212-000-015

Policyholder: OneBeacon Services, LLC

You are hereby notified that, for all purposes on and after the Effective Date specified above, Atlantic Specialty Insurance Company ("Atlantic Specialty") has assumed liability for your policy of insurance originally issued by OneBeacon America Insurance Company ("OneBeacon America").

On and after the Effective Date, Atlantic Specialty has assumed all rights and duties under your policy and all references in the policy to OneBeacon America are hereby changed to Atlantic Specialty. All correspondence and inquiries such as policy changes and notices of claims should continue to be submitted to the current addresses under the company name of Atlantic Specialty Insurance Company.

This Certificate of Assumption forms a part of and should be attached to the insurance policy issued to you by OneBeacon America.

IN WITNESS WHEREOF, Atlantic Specialty Insurance Company has caused this Certificate of Assumption to be duly signed and issued.

Secretary

President

ERISA
SUMMARY PLAN DESCRIPTION
INFORMATION

The plan described in this Certificate, together with the following information, constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 as amended.

The Plan Sponsor is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Employer Identification Number (EIN) is:	26-3300555
The Plan Number is:	509
The Plan Administrator is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Claims Fiduciary is:	Intact Services USA LLC
The agent for the service of legal process is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441 800-527-1255

The benefits of the Plan are provided under Policy No. 212-000-015 underwritten by OneBeacon America Insurance Company located in Canton, MA with administrative offices in Morristown, NJ.

The plan is financed through contributions made by: The Employees of Intact Services USA LLC

Plan Year Ends: December 31

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this Certificate.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw, or amend the plan in whole or in part at any time, subject to the applicable provisions of the Policy.

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from the Plan Administrator. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you, your beneficiary or a legally authorized representative may simply supply the appropriate party with a written statement outlining proof and extent of loss. Complete the claim form according to directions and return the claim form to the Plan Administrator.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of the 90 day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary, you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under "Claim Review Procedure."

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What if your Benefits are denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90 day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1. the specific reason(s) for the denial of the claim;
2. a specific reference to the provision(s) of the Group Policy upon which the denial is based;
3. a description of any additional information or material needed and why; and
4. notice of your rights to have the denial reviewed by the insurance company, and to bring suit under ERISA if the review also results in an adverse benefit determination.

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the insurance company. This request for a review must be made to the insurance company within 60 days of the receipt of denial by the insurance company. If such request is not made within 60 days you will be deemed to have waived your right to a review.

Once the insurance company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim, including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the insurance company will notify you in writing of the results, citing plan provisions that control the decision. The insurance company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the insurance company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the insurance company will have an additional 60 days to notify you of the decision on your denied claim.

What If Your Benefits Continue To Be Denied?

If your claim for benefits continues to be denied, you will receive written notice of such continued denial within the 60-day period stated above (or 120 days if an extension period is required).

The written notice of denial shall set forth:

1. the specific reason(s) for the continued denial on review of the claim;
2. reference to the specific plan provision(s) on which the denial on review is based;
3. a statement regarding your right to access and receive copies of relevant documents, records and other information upon request, without charge; and
4. notice of your rights to pursue other voluntary dispute resolution alternatives, if available, and to bring suit under ERISA.

Statement of ERISA Rights

Your Rights under ERISA: Your Employer intends to comply fully with the Employee Retirement Income Security Act of 1974 and the regulations under the Act as it understands them. The Act provides for certain rights and protections for each participant of the Plan. As a participant in this Group Insurance Plan you may:

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Our Policy Regarding Your Privacy

In order to provide the insurance products and services that respond to our customers' diverse needs, OneBeacon Insurance Group collects certain personal information. OneBeacon Insurance Group does not disclose any nonpublic personal information to any affiliated or nonaffiliated third party for marketing purposes. At OneBeacon Insurance Group, maintaining the confidentiality of our customers' personal information is of the highest importance. OneBeacon Insurance Group personal information-handling practices are governed by this privacy policy and are further regulated by law. This notice describes those practices and how they preserve your privacy in a way that permits OneBeacon Insurance Group to provide you with the products and service you demand.

Collection of Personal Information

We get most of our information directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other potential insureds from outside sources such as motor vehicle records, loss information reports, credit reports, court records or other public records. For property insurance, we may send someone to inspect your property and verify information about its value and condition, and a photo of the property may be taken.

We also may obtain information from third parties such as other insurance companies or consumer reporting agencies. A consumer report from such an agency may contain information as to credit worthiness and credit standing. If we order any kind of consumer report, upon request, we will tell you how to get a copy of the report. The agency preparing a consumer report for us may keep the information collected about you as permitted by law, and it may be disclosed to other persons.

Disclosure of Personal Information

Information which has been collected about you will be contained in either our policy records or in your producer's files. We review it in evaluating your request for insurance coverage and in determining your rates. We will also use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. OneBeacon Insurance Group may disclose personal information to others in order to service, process or administer business such as underwriting and claims operations. In this context, OneBeacon Insurance Group may disclose **(i)** information we receive from you on applications and other forms, including information such as assets, income, and identifying information such as name, address and social security number; **(ii)** transaction information such as information about balances, payment history and parties to the transaction; and **(iii)** information from consumer reporting agencies such as a consumer's credit worthiness and credit history.

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report, we will tell you as required by state law and the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report.

Parties to Whom Information May be Disclosed

OneBeacon Insurance Group will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, OneBeacon Insurance Group is permitted to share information about you without prior permission under certain circumstances to certain persons and organizations such as:

- Your producer.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Claim adjusters, appraisers, investigators and attorneys who need the information to investigate, defend or settle a claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes and fraudulent claims.
- Insurance regulatory agencies in connection with the regulation of our business.
- Law enforcement or other governmental authorities to protect our legal interest, or in cases of suspected fraud or illegal activities.
- Authorized persons as ordered by subpoena, warrant or other court order or as required by law.
- Lien holder, mortgagee, assignee, lessor, or other person shown on our records or our producer’s as having a legal or beneficial interest in a policy of insurance.
- Parties acting in a fiduciary or representative capacity to you (attorneys, accountants and auditors).
- Insurance rate advisory organizations.
- Parties enforcing OneBeacon Insurance Group rights in connection with the settlement of a debt, the transfer of interests or an audit.
- Parties administering transactions as requested or authorized by you.

Right of Access to Personal Information

You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and to receive a copy. Write to us if you have questions about the information. Provide your complete name, address, type of policy and policy number that was issued or applied for with us. Mail your request to: Privacy Administrator, Post Office Box 254, Canton, MA, 02021-0254. Certain types of information generally collected when evaluating claims or possible lawsuits need not be disclosed to you.

Within thirty (30) business days of receipt of your request, we will inform you in writing of the nature and substance of retrievable recorded personal information about you in our files. You may review this information in person or receive a copy by mail. We will also identify the person or organization to which we have disclosed this information within the past two (2) years. In addition, you will be given the name and address of any consumer reporting agency which prepared a report about you so that you can contact them for a copy.

After you have reviewed the personal information about you in our file, you can write to us if you believe it should be corrected, amended or deleted. We will consider your request, and within thirty (30) days either change the information or tell you that we did not and state the reason. If we do not make changes, you will have the right to insert in our file a concise statement containing what you believe to be the correct, relevant or fair information, and explaining which information on file you believe to be improper. We will notify persons designated by you to whom we have previously disclosed the information of the change or your statement. Subsequent disclosures we make also will include your statement.

Confidentiality and Security of Personal Information

Our company maintains appropriate standards and procedures to prevent unauthorized access to your information. OneBeacon Insurance Group limits employee access to personally identifiable information to those with a business reason for knowing such information. We educate our employees so that they will understand the importance of confidentiality of personal information and take appropriate measures to enforce privacy responsibilities.

Treatment of Personal Information of Former Customers

OneBeacon Insurance Group follows this personal information privacy policy even when a customer relationship no longer exists.

If you have additional questions about the privacy of your personal information or about your insurance needs in general, please contact your producer.

Effective July 1, 2001