Lloyd's Certificate

This Insurance is effected with certain Underwriters at Lloyd's, London.

This Certificate is issued in accordance with the limited authorization granted to the Correspondent by certain Underwriters at Lloyd's, London whose syndicate numbers and the proportions underwritten by them can be ascertained from the office of the said Correspondent (such Underwriters being hereinafter called "Underwriters") and in consideration of the premium specified herein, Underwriters hereby bind themselves severally and not jointly, each for his own part and not one for another, their Executors and Administrators.

The Assured is requested to read this Certificate, and if it is not correct, return it immediately to the Correspondent for appropriate alteration.

All inquires regarding this Certificate should be addressed to the following Correspondent:

SEVENCORNERS

303 Congressional Boulevard
Carmel, IN 46032
1-800-335-0611
317-575-2652
317-575-2659 FAX
www.sevencorners.com

CERTIFICATE PROVISIONS

1. Signature Required. This Certificate shall not be valid unless signed by the Correspondent on the attached Declaration Page.

2. Correspondent Not Insurer. The Correspondent is not an Insurer hereunder and neither is nor shall be liable for any loss or claim whatsoever. The Insurers hereunder are those Underwriters at Lloyd's, London whose syndicate numbers can be ascertained as hereinbefore set forth. As used in this Certificate "Underwriters" shall be deemed to include incorporated as well as unincorporated persons or entities that are Underwriters at Lloyd's, London.

3. Cancellation. If this Certificate provides for cancellation and this Certificate is cancelled after the inception date, earned premium must be paid for the time the insurance has been in force.

4. Service of Suit. It is agreed that in the event of the failure of Underwriters to pay any amount claimed to be due hereunder, Underwriters, at the request of the Assured, will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Underwriters' rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States. It is further agreed that service of process in such suit may be made upon Mendes and Mount; 750 Seventh Avenue; New York, NY 10019-6829 USA (For California residents, contact Eileen Ridley, FLWA Service Corp., c/o Foley & Lardner LLP, 555 California Street, Suite 1700, San Francisco, CA 94104-1520 USA.), and that in any suit instituted against any one of them upon this contract, Underwriters will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Underwriters in any such suit and/or upon request of the Assured to give a written undertaking to the Assured that they will enter a general appearance upon Underwriters' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, Underwriters hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Assured or any beneficiary hereunder arising out of this contract of insurance, and hereby designate the above-mentioned as the person to whom the said officer is authorized to mail such process or a true copy thereof.

5. Assignment. This Certificate shall not be assigned either in whole or in part without the written consent of the Correspondent endorsed hereon.

6. Attached Conditions Incorporated. This Certificate is made and accepted subject to all the provisions, conditions and warranties set forth herein, attached or endorsed, all of which are to be considered as incorporated herein.

7. Short Rate Cancellation. If the attached provisions provide for cancellation, the table below will be used to calculate the short rate proportion of the premium when applicable under the terms of cancellation.

Short Rate Cancellation Table for Term of Three Hundred and Sixty-four (364) Days.

Days Insurance In Force	Per Cent of Policy Period Premium	Days Insurance In Force	Per Cent of Policy Period Premium	Days Insurance In Force	Per Cent of Policy Period Premium	Days Insurance In Force	Per Cent of Policy Period Premium
1	5 %	66 - 69	29 %	154-156	53 %	256-260	77 %
2	6	70 - 73	30	157-160	54	261-264	78
3 - 4	7	74 - 76	31	161-164	55	265-269	79
5 - 6	8	77 - 80	32	165-167	56	270-273 (9 mos.)	80
7 - 8	9	81 - 83	33	168-171	57	274-278	81
9 - 10	10	84 - 87	34	172-175	58	279-282	82
11-12	11	88 -91 (3 mos.)	35	176-178	59	283-287	83
13-14	12	92 - 94	36	179-182 (6 mos.)	60	288-291	84
15-16	13	95 - 98	37	183-187	61	292-296	85
17-18	14	99 -102	38	188-191	62	297-301	86
19-20	15	103-105	39	192-196	63	302-305 (10 mos.)	87
21-22	16	106-109	40	197-200	64	306-310	88
23-25	17	110-113	41	201-205	65	311-314	89
26-29	18	114-116	42	206-209	66	315-319	90
30-32 (1 mos.)	19	117-120	43	210-214 (7 mos.)	67	320-323	91
33-36	20	121-124(4 mos.)	44	215-218	68	324-328	92
37-40	21	125-127	45	219-223	69	329-332	93
41-43	22	128-131	46	224-228	70	333-337 (11 mos.)	94
44-47	23	132-135	47	229-232	71	338-342	95
48-51	24	136-138	48	233-237	72	343-346	96
52-54	25	139-142	49	238-241	73	347-351	97
55-58	26	143-146	50	242-246 (8 mos.)	74	352-355	98
59-62 (2 mos.)	27	147-149	51	247-250	75	356-360	99
63-65	28	150-153 (5 mos.)	52	251-255	76	361-364	100

Rules applicable to insurance with terms less than or more than three hundred and sixty-four (364) days:

A. If insurance has been in force for three hundred and sixty-four (364) days or less, apply the short rate table for three hundred and sixty-four (364) days of insurance to the full Policy Period premium determined as for insurance written for a term of three hundred and sixty-four (364) days.

B. If insurance has been in force for more than three hundred and sixty-four (364) days:
   1. Determine full-Policy Period premium as for insurance written for a term of three hundred and sixty-four (364) days.
   2. Deduct such premium from the full insurance premium, and on the remainder calculate the pro rata earned premium on the basis of the ratio of the length of time beyond three hundred and sixty-four (364) days the insurance has been in force to the length of time beyond three hundred and sixty-four (364) days for which the policy was originally written.
   3. Add premium produced in accordance with items (1) and (2) to obtain earned premium during full period insurance has been in force.

CERTIFICATE OF INSURANCE DECLARATIONS

Inbound Choice
LON15-150415-02TM

This Declaration is attached to and forms part of certificate provisions

ITEM 1.
NAMED INSURED AND MAILING ADDRESS: AS STATED ON THE ID CARD

Inbound Choice
World Commercial Trust
Tortola, British Virgin Islands

ITEM 2. POLICY PERIOD: AS STATED ON THE ID CARD TERM: AS STATED ON THE ID CARD

[X] 12:01 A.M., North American Eastern Time at your mailing address

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS CERTIFICATE, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS CERTIFICATE.
International Travel Medical Coverage:

Inbound Choice
Daily Rates (Effective November 18, 2013)

$0 Per Injury / Sickness Deductible Per Person

	Plan A ($50,000 Maximum)			Plan B ($75,000 Maximum)			Plan C ($100,000 Maximum)			Plan D ($130,000 Maximum)		
Age Bands	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium
2 weeks - 18	$ 1.08	2%	$ 1.06	$ 1.36	2%	$ 1.33	$ 1.62	2%	$ 1.59	$ 2.21	2%	$ 2.17
19 - 29	$ 1.14	2%	$ 1.12	$ 1.43	2%	$ 1.40	$ 1.71	2%	$ 1.68	$ 2.33	2%	$ 2.28
30 - 39	$ 1.38	2%	$ 1.35	$ 1.62	2%	$ 1.59	$ 1.90	2%	$ 1.86	$ 2.47	2%	$ 2.42
40 - 49	$ 1.38	2%	$ 1.35	$ 1.62	2%	$ 1.59	$ 1.90	2%	$ 1.86	$ 2.47	2%	$ 2.42
50 - 59	$ 1.90	2%	$ 1.86	$ 2.23	2%	$ 2.19	$ 2.57	2%	$ 2.52	$ 3.37	2%	$ 3.30
60 - 69	$ 2.19	2%	$ 2.15	$ 2.57	2%	$ 2.52	$ 2.95	2%	$ 2.89	$ 3.80	2%	$ 3.73
Dep. Child*	$ 1.05	2%	$ 1.03	$ 1.33	2%	$ 1.30	$ 1.57	2%	$ 1.54	$ 2.09	2%	$ 2.05

$50 Per Injury / Sickness Deductible Per Person

	Plan A ($50,000 Maximum)			Plan B ($75,000 Maximum)			Plan C ($100,000 Maximum)			Plan D ($130,000 Maximum)		
Age Bands	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium	Daily Charge	Trust Fee	Daily Premium
2 weeks - 18	$ 0.90	2%	$ 0.88	$ 1.08	2%	$ 1.06	$ 1.26	2%	$ 1.24	$ 1.76	2%	$ 1.73
19 - 29	$ 0.95	2%	$ 0.93	$ 1.14	2%	$ 1.12	$ 1.33	2%	$ 1.30	$ 1.85	2%	$ 1.81
30 - 39	$ 1.14	2%	$ 1.12	$ 1.33	2%	$ 1.30	$ 1.52	2%	$ 1.49	$ 2.04	2%	$ 2.00
40 - 49	$ 1.14	2%	$ 1.12	$ 1.33	2%	$ 1.30	$ 1.52	2%	$ 1.49	$ 2.04	2%	$ 2.00
50 - 59	$ 1.57	2%	$ 1.54	$ 1.85	2%	$ 1.81	$ 2.09	2%	$ 2.05	$ 2.80	2%	$ 2.75
60 - 69	$ 1.85	2%	$ 1.81	$ 2.14	2%	$ 2.10	$ 2.42	2%	$ 2.37	$ 3.18	2%	$ 3.12
Dep. Child*	$ 0.86	2%	$ 0.84	$ 1.09	2%	$ 1.07	$ 1.28	2%	$ 1.25	$ 1.71	2%	$ 1.68

$100 Per Injury / Sickness Deductible Per Person

	Plan A ($50,000 Maximum)			Plan B ($75,000 Maximum)			Plan C ($100,000 Maximum)			Plan D ($130,000 Maximum)		
Age Bands	**Daily Charge**	**Trust Fee**	**Daily Premium**	**Daily Charge**	**Trust Fee**	**Daily Premium**	**Daily Charge**	**Trust Fee**	**Daily Premium**	**Daily Charge**	**Trust Fee**	**Daily Premium**
2 weeks - 18	$ 0.82	2%	$ 0.80	$ 1.00	2%	$ 0.98	$ 1.18	2%	$ 1.16	$ 1.62	2%	$ 1.59
19 - 29	$ 0.86	2%	$ 0.84	$ 1.05	2%	$ 1.03	$ 1.24	2%	$ 1.22	$ 1.71	2%	$ 1.68
30 - 39	$ 1.05	2%	$ 1.03	$ 1.24	2%	$ 1.22	$ 1.43	2%	$ 1.40	$ 1.90	2%	$ 1.86
40 - 49	$ 1.05	2%	$ 1.03	$ 1.24	2%	$ 1.22	$ 1.43	2%	$ 1.40	$ 1.90	2%	$ 1.86
50 - 59	$ 1.43	2%	$ 1.40	$ 1.76	2%	$ 1.73	$ 2.04	2%	$ 2.00	$ 2.71	2%	$ 2.66
60 - 69	$ 1.71	2%	$ 1.68	$ 2.04	2%	$ 2.00	$ 2.38	2%	$ 2.33	$ 3.09	2%	$ 3.03
Dep. Child*	$ 0.81	2%	$ 0.79	$ 1.00	2%	$ 0.98	$ 1.14	2%	$ 1.12	$ 1.57	2%	$ 1.53

*Dependent Child (Ages 2 weeks to 18) rate is applicable when at least one parent will also be covered under Inbound Choice.

Mode

Premium payable, In Advance:

This certificate of Insurance is made and accepted subject to the foregoing stipulations and conditions together with such other provisions, agreement or conditions as may be endorsed or added here to.

Dated: 04/13/15

By:_____
(Correspondent – James J. Krampen, Jr.)

Certain Underwriters at Lloyds, London

(Herein called the Company)

Certain Underwriters at Lloyd's, London, herein referred to as "the Company" hereby insures all persons whose Application has been Approved, by Seven Corners, herein referred to as "the Administrator" on behalf of the Company and whose name is identified on the ID Card and/or recorded with the Administrator, subject to all of the Exclusions, Limitations and Provisions as set forth herein and in the Certificate of Insurance issued by the Company to the Policyholder. Coverage is afforded only with respect to the named Insured Person(s), Coverage, amounts and limits specified herein and as identified in the Schedule of Benefits for the Insurance requested on the Application and for which the specified Premium has been paid to the Administrator.

Inbound Choice

This document is a Program Summary outlining the full description in the Inbound Choice Policy, LON15-150415-02TM

Administrator
Seven Corners, Inc.
303 Congressional Blvd., Carmel, IN 46032
800-335-0611 or 317-575-2652 fax: 317-575-2659 - www.sevencorners.com

Seven Corners Assist
800-690-6295 or 317-818-2808
Fax 317-815-5984 – assist@sevencorners.com

Seven Corners Claims Office
800-335-0477 or 317-575-2656
Fax 317-575-2256 – claims@sevencorners.com

Seven Corners Assist must be contacted:

- As soon as non-emergency hospitalization is recommended.
- Within 48 hours of an emergency admission.
- When your physician recommends any surgery, including outpatient.
- Before receiving any medical treatment inside the United States
- For emergency evacuation, return of remains and assistance services.

Claims Submission:

- All claims must be submitted to Seven Corners within 90 days of the date of service.
- Claims may be mailed, faxed, or scanned. Contact details provided above.
- A Proof of Loss form must be completed and provided for each medical condition.
- A copy of your passport with entry/exit/visa stamps is required.
- Detailed bills for services received and detailed receipts for payments made.
- A signed authorization from the Insured is necessary to reimburse any person other than the Insured.

ELIGIBILITY

Persons who are non-US citizens, from fourteen (14) days of age and have not yet reached their seventieth* (70) birthday who are traveling to the United States for business, pleasure, to study or to visit who have arrived in the United States within the twenty-four (24) months prior to the proposed Effective Date, who have paid premium as outlined in the enrollment application, and who have completed the enrollment form in complete detail are eligible for Inbound Choice. The Company maintains its right to investigate to verify that the eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependent Child(ren) of a Named Insured (as defined) shall be determined in accordance with the following: (1) If a Named Insured has Dependent Child(ren) on the date he or she is eligible for insurance; or (2) If a Named Insured acquires Dependent Child(ren) after the Effective date, such Dependent Child(ren) becomes eligible on the date the Insured acquires a Dependent Child who is within the limits of a dependent, unmarried child set forth in the "Definition" section of the policy. Dependent Child(ren) eligibility expires concurrently with that of the Named Insured.

*Individuals who have their 70th birthday during their Policy Period will continue to be covered through their current Policy Period but will not be allowed to renew once that Policy Period expires.

EFFECTIVE DATE

Effective Date under the program shall become effective at 12:01 AM North American Eastern Time on the latest of the following dates:

1. The Named Insured's departure from his Home Country; or
2. The date the application and premium are received by the Administrator; or
3. The date the application and premium are accepted by the Administrator; or
4. The date requested on the application.

Dependent Child(ren) coverage will not be effective prior to that of the Named Insured.

EXPIRATION DATE

The coverage provided with respect to the Named Insured shall terminate at 12:01 AM North American Eastern Time on the earliest of the following dates:

1. The date shown on the insurance confirmation card, for which the premium is paid; or
2. The thirty-first (31st) day of any Insured Person's return trip to his or her Home Country whether days of the trip are consecutive or not; or
3. After three hundred and sixty four (364) days of coverage, unless the company agrees to extend coverage upon such expiration; or
4. The date the Named Insured becomes a United States citizen; or
5. The date of entry into active duty military service; or

6. The date the master policy terminates (unless the Company agrees, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
7. In addition, for Dependent Child(ren), coverage expires the date the Named Insured(s) coverage expires or the date they cease to be considered a Dependent Child.

DEFINITIONS

"ACCIDENT" or **"ACCIDENTAL"** shall mean an event, independent of Illness or self-inflicted means, which is the direct cause of bodily Injury to an Insured Person.
"ACUTE ONSET OF A PRE-EXISTING CONDITION(S)" shall mean a sudden and unexpected outbreak or recurrence of a Pre-existing Condition(s) which occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms and is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-existing Condition(s) must occur after the effective date of the policy. **Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence.** A Pre-existing Condition that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or Treatments existent or necessary prior to arrival in the United States and prior to the Effective Date of coverage.
"BENEFIT PERIOD" shall mean the duration of time following an Eligible Accident, Injury or Illness in which to receive Medically Necessary Covered Expenses. If Your plan terminates during Your Benefit Period, You will still be eligible to receive Treatment so long as the treatment is within Your Benefit Period and outside Your Home Country (except as provided under the Home Country Coverage). Treatment due to an Injury must be performed by a Physician and meet the following conditions: a) begin within thirty (30) days after date of Injury; and b) be received within three hundred and sixty-four (364) after date of Injury; or Due to Sickness of an Insured Person provided Covered Medical Expenses are incurred within three hundred and sixty-four (364) after the date of first treatment for such Sickness.
"CERTIFICATE" shall mean the summary of the terms of Coverage, which includes this document, the Insured Person's Application and any endorsements or amendments that will attach during the Insured Person's Period of Coverage.
"COMPANY" shall mean Certain Underwriters at Lloyd's, London
"COVERED MEDICAL EXPENSES" means reasonable charges which are: 1) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 2) made for services and supplies not excluded under the policy; 3) made for services and supplies which are a Medical Necessity; 4) made for services included in the Schedule of Benefits; and 5) in excess of the amount stated as a deductible, if any. Covered medical expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.
"DISABLEMENT" as used with respect to medical expenses shall mean an Illness or an Accidental bodily Injury necessitating medical treatment by a Physician as defined in this Policy.
"DEDUCTIBLE" means the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company. Such amount will be subtracted from the amount or amounts charged and otherwise payable as Covered Medical Expenses. The deductible will apply per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.
"DEPENDENT CHILD(REN)" means a Named Insured's dependent, unmarried child(ren) who are a minimum of 14 days old, and under the age of 19 living with the Named Insured. This includes stepchildren, legally adopted children and children of adopting parents pending adoption procedures. Children shall cease to be dependent on the first occurrence of: (1) the end of the month in which they marry; or (2) the end of the month in which they attain the age of nineteen (19) years. The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) chiefly dependent upon the Insured Person for support and maintenance. Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and 2) within thirty-one (31) days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company upon request following the child's attainment of the limiting age. If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsection (1) and (2).
"ELIGIBLE BENEFIT(S)" shall mean benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this program and which do not exceed the maximum benefit.
"EMERGENCY" shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.
"EXPERIMENTAL/INVESTIGATIONAL" means all services or supplies associated with: 1) treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the treatment or diagnostic evaluation to be considered effective such articles should indicate that it is more effective than others available; or if less effective than other available treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical device which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devises, or is safer or less costly. The Company will make the final determination as to whether a service or supply is Experimental/Investigational.
"EXCESS PROVISION" means the plan benefits are payable for covered expenses not covered and payable by any other plan providing medical expense benefits. If there is no other valid and collectible benefits available from any other source, this plan will pay the covered expenses up to the limits of the policy.
"HOME COUNTRY" means the country where the Insured Person's Passport was issued.
"HOSPITAL" means a licensed or properly accredited general Hospital which; 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured person as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorders.
"HOSPITAL CONFINED/HOSPITAL CONFINEMENT" means confined in a Hospital for at least eighteen (18) hours by reason of an Injury or Sickness for which benefits are payable.
"ILLNESS" wherever used in this Policy shall mean any medical condition, sickness, disease, disability, birth defect, congenital defect , chronic infirmity or disorder of any kind. Provided, however, that Illness does not include any learning disabilities or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.
"INJURY" means bodily Injury: 1) directly and independently caused by specific accident which is unrelated to any pathological, functional, or structural disorder or Injury; 2) treated by a Physician within thirty (30) days after the date of accident; and 3) which causes loss during the term of the policy.
"INPATIENT" shall mean a person who is confined in an institution for a period of 24 hours or more and is charged for room and board.
"INSURED PERSON" shall mean a person eligible for Coverage under the Certificate as stated on the ID Card, who has applied for Coverage and is named on the Application and for whom the Company has Approved for Coverage and accepted the corresponding Premium. This may be the Primary Insured Person or Dependent(s) who are a minimum of 14 days old to age 18.
"INTENSIVE CARE" means (1) a specifically designated facility of the Hospital that provides the highest level of medical care; and (2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
"LOSS" in reference to quadriplegia, paraplegia, hemiplegia, and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through and above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss of sight.

"MEDICAL EMERGENCY" means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: (1) Death; (2) Permanent placement of the Insured's health in jeopardy; (3) Serious impairment of bodily functions; or (4) Serious and permanent dysfunction of any body organ or part. Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor Sicknesses.
"MEDICAL NECESSITY/MEDICALLY NECESSARY" means those services or supplies provided or prescribed by a Hospital or Physician which are: (1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury; (2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury; (3) In accordance with the standards of good medical practice; (4) Not primarily for the convenience of the Insured, or the Insured's Physician; and (5) The most appropriate supply or level of service which can safely be provided to the Insured. The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and 2) the Insured cannot receive safe and adequate care as an outpatient. The policy only provides payment for services, procedures and supplies which in the judgement of the Company are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.
"MENTAL AND NERVOUS DISORDER" means a Sickness that is a mental, emotional or behavioral disorder.
"NAMED INSURED" means an eligible person who: 1) has completed an application; and 2) has paid appropriate premium for coverage and been accepted by the Administrator.
"OUTPATIENT" shall mean an Insured Person who receives care in a Hospital or another institution, including: ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for an Illness or Injury, but who is confined and is not charged for room and board.
"PHYSICIAN" means a person, other than the Insured or a member of the Insured's family, or any person who ordinarily resides with the Insured Person who holds a medical license or medical certificate. In this Policy shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.
"PHYSIOTHERAPY" means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.
"POLICY PERIOD OR PERIOD OF COVERAGE" shall mean the period of coverage issued by the Company to the Insured Person, typically beginning with the Effective Date and ending with the Termination Date or the date coverage is renewed by the Company. Maximum Period of Coverage is three hundred and sixty-four (364) days.
"POLICYHOLDER" means Global International Trust, Washington DC.
"PRE-EXISTING CONDITION" shall mean any medical condition, sickness, Injury, Illness, disease, Mental Illness or Mental Nervous Disorder, regardless of the cause including any congenital, chronic, subsequent, or recurring complications or consequences related thereto or resulting therefrom that with reasonable medical certainty existed at the time of application or within the one hundred and eighty (180) days immediately prior to the Insured Person's Effective Date under the policy, whether or not previously manifested, symptomatic, known, diagnosed, treated or disclosed. This specifically includes but is not limited to any medical condition, sickness, Injury, Illness, disease, Mental Illness or Mental Nervous Disorder, for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the one hundred and eighty (180) days immediately preceding the effective date of coverage under this policy.
"PRESCRIPTION DRUGS" means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.
"RELATIVE" shall mean spouse, parent, sibling, child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.
"SERVICE PROVIDER" shall mean a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, dentist, chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.
"**SICKNESS"** means Sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under the policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.
"SOUND, NATURAL TEETH" means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed or defective.
"SURGERY" shall mean an invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.
"TREATMENT(S)" shall mean medical or surgical management of a patient designed to resolve the Illness(es) or Injury(ies) based on standard and accepted medical practice. For purposes of this Certificate, the course of action will only include those scheduled and approved benefits, for which the Insured Person(s) is eligible.

SCHEDULE OF BENEFITS

INJURY AND SICKNESS MEDICAL BENEFITS (PART A)
Maximum Benefit Limit Per Sickness or Injury:
Ages 14 days through 69: Option $50,000 (Plan A), $75,000 (Plan B), $100,000 (Plan C), or $130,000 (Plan D)

Deductible Per Person Per Sickness or Injury:
Ages 14 days through 69: Option $0, $50, or $100
No Coinsurance applies.

Age 14 Days through 69	Plan A	Plan B	Plan C	Plan D
	$50,000 Max per Injury/Sickness	**$75,000 Max per Injury/Sickness**	**$100,000 Max per Injury/Sickness**	**$130,000 Max per Injury/Sickness**
INPATIENT				
Hospital Room & Board Including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to $1,500/day, 30 day max	Up to $2,000/day, 30 day max	Up to $2,500/day, 30 day max	Up to $3,000/day, 30 day max
Hospital Intensive Care Unit	Additional $500/day, 8 day max	Additional $500/day, 8 day max	Additional $500/day, 8 day max	Additional $800/day, 8 day max
Surgical Treatment	Up to $2,100	Up to $4,800	Up to $5,800	Up to $7,200
Anesthetist	Up to $500	Up to $750	Up to $1,000	Up to $1,650
Assistant Surgeon	Up to $500	Up to $750	Up to $1,000	Up to $1,650
Physician's Non-Surgical Visits	Up to $38/visit, 1/day,	Up to $56/visit, 1/day, 30	Up to $75/visit, 1/day, 30 visits	Up to $100/visit, 1/day,

	30 visits max	visits max	max	30 visits max
A Consulting Physician, when requested by attending Physician	Up to $250	Up to $325	Up to $500	Up to $575
Private Duty Nurse	Up to $650	Up to $650	Up to $650	Up to $650
Pre-Admission Tests w/in 7 days before Hospital admission	Up to $650	Up to $975	Up to $1,300	Up to $1,300
OUTPATIENT				
Surgical Treatment	Up to $2,100	Up to $4,800	Up to $5,800	Up to $7,200
Anesthetist	Up to $500	Up to $750	Up to $1,000	Up to $1,650
Assistant Surgeon	Up to $500	Up to $750	Up to $1,000	Up to $1,650
Physician's Non-Surgical/ Urgent Care Visits	Up to $38/visit, 1/day, 10 visits max	Up to $56/visit, 1/day, 10 visits max	Up to $75/visit, 1/day, 10 visits max	Up to $100/visit, 1/day, 10 visits max
Diagnostic X-rays & Lab Services	Up to $250 - Additional $325- One CAT scan, PET scan or MRI	Up to $375 - Additional $325 - One CAT scan, PET scan or MRI	Up to $500 - Additional $975 – One CAT scan PET or MRI	Up to $575 -Additional $975 - One CAT scan, PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to $200	Up to $300	Up to $400	Up to $650
Prescription Drugs	Up to $68	Up to $101	Up to $135	Up to $200
Outpatient Surgical Facility - Day surgery miscellaneous, related to outpatient scheduled surgery performed at a Hospital or licensed outpatient surgery center; including the cost of the operating room, anesthesia, drugs and medicines and medical supplies.	Up to $600	Up to $900	Up to $1,200	Up to $1,400
OTHER TREATMENT AND SERVICES				
Ambulance Services	Up to $500	Up to $500	Up to $500	Up to $500
Initial Orthopedic Prosthesis/brace	Up to $663	Up to $994	Up to $1,325	Up to $1,600
Chemotherapy and/or radiation therapy	Up to $663	Up to $994	Up to $1,325	Up to $1,600
Dental Treatment for Injury to Sound, Natural Teeth	Up to $650	Up to $650	Up to $650	Up to $650
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to $45/visit, 1/day, 12 visits max	Up to $45/visit, 1/day, 12 visits max	Up to $45/visit, 1/day, 12 visits max	Up to $45/visit, 1/day, 12 visits max
Emergency Evacuation	$50,000	$50,000	$50,000	$50,000
Return of Remains	$25,000	$25,000	$25,000	$25,000
AD&D Principal Sum	$25,000 Common Carrier	$25,000 Common Carrier	$25,000 Common Carrier	$25,000 Common Carrier
Acute Onset of Pre-existing Condition(s)	$50,000 ***per policy period*** for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 ***per policy period*** for Emergency Medical Evacuation.	$75,000 ***per policy period*** for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 ***per policy period*** for Emergency Medical Evacuation.	$100,000 ***per policy period*** for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 ***per policy period*** for Emergency Medical Evacuation.	$130,000 ***per policy period*** for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 ***per policy period*** for Emergency Medical Evacuation.

EMERGENCY EVACUATION AND RETURN OF REMAINS (PART B)

BENEFIT	MAXIMUM AMOUNT
Emergency Evacuation	$50,000 maximum benefit per Injury or Sickness
Return of Remains	$25,000 maximum benefit

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT (PART C)

BENEFIT	PRINCIPAL SUM
Accidental Death & Dismemberment	$25,000

A. MEDICAL EXPENSE BENEFITS – INJURY AND SICKNESS

When a covered Injury or Sickness requires treatment by a Physician, the policy will provide benefits for the maximum benefit amount payable per service as specified in the Schedule of Benefits for Medically Necessary Covered Medical Expenses which exceed the deductible per person for each Injury or Sickness. The total payable for all Covered Medical Expenses will be no more than the Maximum Benefit Limit per Sickness or Injury. Benefits are subject to the Excess Provision.

Covered Medical Expenses will be paid under the Schedule of Benefits for loss:

1) Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within thirty (30) days after date of Injury; and b) is received within three hundred and sixty-four (364) days after date of Injury; or
2) Due to Sickness of an Insured Person provided Covered Medical Expenses are incurred within three hundred and sixty-four (364) days after the date of first treatment for such Sickness.

If a benefit is designated in the Schedule of Benefits, Covered Medical Expenses include:

1) Room and Board Expense: 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged for by the Hospital.
2) Intensive Care.
3) Hospital Miscellaneous Expenses: 1) while Hospital Confined; or 2) for pre-admission expenses for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; x-ray examination; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
4) Physiotherapy (inpatient).
5) Surgery: Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not for both.
6) Anesthetist Services: in connection with inpatient surgery.
7) Private Duty Nurse's Services: 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
8) Physician's Visits: when Hospital Confined. Benefits are limited to one Physician's visit per day. Benefits do not apply when related to surgery. Covered medical expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits but not both.
9) Pre-admission Testing: limited to routine tests such as: complete blood count; urinalysis; and chest x-ray. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.
10) Mental and Nervous Disorder (inpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
11) Surgery (outpatient): Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered medical expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both.
12) Day Surgery Miscellaneous (Outpatient): in connection with outpatient day surgery; excluding non-scheduled surgery, and surgery performed in a Hospital emergency room, trauma center, Physician's office, or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs or medicines, therapeutic services and supplies.
13) Anesthetist (Outpatient): in connection with outpatient surgery.
14) Physician's Visits (Outpatient): Includes injections administered during visit. Benefits do not apply when related to surgery or Physiotherapy. Covered medical expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's visits but not both.
15) Medical Emergency Expenses (Outpatient): only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies.
16) Radiation Therapy (Outpatient)
17) Chemotherapy (Outpatient)
18) Prescription Drugs (Outpatient)
19) Mental and Nervous Disorder (Outpatient): the benefits and the maximum amounts are specified in the Schedule of Benefits. Benefits are limited to one Physician's visit per day.
20) Ambulance Service.
21) Braces and Appliances: 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment which is equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
22) Consultant Physician Fees: when requested and approved by the attending Physician.
23) Dental Treatment: 1) performed by a Physician; and 2) made necessary by Injury to Sound, Natural Teeth. Routine dental care and treatment to the gums are not covered.
24) Alcoholism/Drug Abuse Treatment: the benefits and the maximum amounts are specified in the Schedule of Benefits.

B. EMERGENCY EVACUATION

The Company will pay benefits for covered expenses incurred up to a maximum of $50,000, if an Injury or Sickness commencing during the Period of Coverage results in the necessary Emergency Evacuation of the Insured Person. An Emergency Evacuation must be ordered by a legally licensed Physician who certifies that the severity of the Insured Person's Injury or Sickness warrants the Emergency Evacuation of the Insured Person. Benefits are subject to the Excess Provision.

Emergency Evacuation means:

a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; or
b) after being treated at a local Hospital, the Insured Person's medical condition warrants transportation to the place where he or she resides to obtain further medical treatment or to recover; or
c) both a) and b) above.

Covered expenses are expenses, up to the maximum, for transportation, medical services and medical supplies necessarily incurred in connection with emergency evacuation of the Insured Person.

All transportation arrangements made for evacuating the Insured Person must be by the most direct and economical route. **Seven Corners Assist must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable**

Covered expenses must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting the Insured Person; and (c) authorized in advance by Seven Corners Assist.
Transportation means any land, water or air conveyance required to transport the Insured Person during an emergency evacuation. Transportation includes, but is not limited to, air ambulance, land ambulance, and private motor vehicles.

C. RETURN OF REMAINS
The Company will pay the reasonable covered expenses incurred to return the Insured Person's body to the Insured Person's Home Country if he or she dies, not to exceed the maximum of $25,000. Benefits are subject to the Excess Provision.
Seven Corners Assist must make all arrangements and must authorize all expenses in advance for any Return of Remains benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Seven Corners Assist in advance.
Covered expenses include, but are not limited to, expenses for embalming, cremation, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations.

D. HOME COUNTRY COVERAGE
Incidental Trips to Your Home Country: This benefit covers the Insured Person for incidental trips to his or her Home country (30 days per three hundred and sixty-four (364) days of purchased coverage or pro rata thereof – example: approximately 2½ days per 30 days of purchased coverage). Maximum benefit is reduced to $50,000 for any illness or injury occurring while on an incidental trip to the Home Country.

E. INTERNATIONAL TRAVEL COVERAGE
An insured person may travel to additional countries, other than the United States, up to a maximum of 30 days. You must purchase a minimum of thirty (30) days of coverage. International travel coverage does not include travel back to the insured person's Home Country, and it does not extend after your current expiration date. International travel must be utilized during your current Period of Coverage**.**

F. ACUTE ONSET OF A PRE-EXISTING CONDITION(S)
If You are a non-U.S. citizen under age 70, traveling in the United States, you are covered for an Acute Onset of a Pre-existing Condition(s) as defined in the Definitions section. To be considered a Covered Expense under this benefit, the expenses for an Acute Onset must be incurred in the United States and must be a result of an Acute Onset which occurs in the United States. Coverage is provided per policy period, to the limit shown in the Schedule of Benefits for Eligible Medical Expenses for your chosen plan (Plan A, B, C and D).Your deductible applies to this coverage, and it is paid according to the sublimits for benefits listed in the Schedule of Benefits above.

An Acute Onset of a Pre-existing Condition(s) is defined as a sudden and unexpected outbreak or recurrence of a Pre-existing Condition(s) which occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms and is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-existing Condition(s) must occur after the effective date of the policy. **Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence.** A Pre-existing Condition that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or Treatments existent or necessary prior to the Effective Date of coverage.

Please see Exclusion #1 in the Exclusions and Limitations section for details.

G. COMMON CARRIER ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY
Accidental Death & Dismemberment Coverage shall apply only to covered accidents sustained by an Insured Person:
1. While riding as a passenger (but not as a pilot, operator or member of the crew) in or on (including getting in or out of, or on or off of):
   A) any land, water or air conveyance operated under a license for the transportation of passengers for hire; or
   B) any Military Air Transport Aircraft; or
2. By being struck down by any aircraft.

The Company shall pay an indemnity determined from the Table of Losses below if an Insured Person sustains a loss stated therein resulting from Injury, provided that:
(a) such loss occurs within three hundred and sixty five (365) days after the date of accident causing such loss; or
(b) the indemnity payable for any such loss shall be the amount stated opposite such loss in said Table and the Principal Sum stated therein shall be the amount stated in the Schedule of Benefits, as applicable to such person and this Coverage; and
(c) if more than one loss stated in said Table is sustained as the result of one accident, only one of the amounts so stated in said Table, the largest, shall be payable.

For Loss of:	**Indemnity**
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot	One-Half the Principal Sum
Sight of One Eye	One-Half the Principal Sum

The term "loss" as used herein shall mean with regard to hands and feet, actual severance through or above wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight.

H. AGGREGATE LIMIT OF INDEMNITY
The Aggregate Limit of Indemnity of $125,000 shall be the total limit of the Company's liability for all indemnities payable under Accidental Death and Dismemberment Indemnity with respect to all classes of Insured Persons arising out of Injury sustained by two (2) or more Insured Persons as the result of any one accident.
If the total of such indemnity exceeds said Aggregate Limit of Indemnity, the Company shall not be liable to any one such Insured Person for a greater proportion of such Insured Person's Indemnity afforded by the Accidental Death and Dismemberment Indemnity than said Aggregate Limit of Indemnity bears to the total Indemnities afforded by this Accident Death and Dismemberment Indemnity to all such Insured Persons.

I. EXCESS PROVISION
All benefits, except Accidental Death and Dismemberment, shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted. If an Insured's Injury or Sickness is due to an act or omission of another, benefits payable by this plan are subject to recovery from amounts eventually paid to the Insured by or on behalf of, the other person.

PREMIUM RATES

PREMIUMS CURRENTLY IN FORCE CAN BE FOUND ON THE CURRENT BROCHURE FOR INBOUND CHOICE

An Eligible Person may enroll for periods of coverage ranging from five (5) days to three hundred and sixty-four (364) days, subject to the following rules: Five (5) days premium is the minimum acceptable premium; three hundred and sixty-four (364) days of premium is the maximum acceptable premium; and the full premium is payable at the time of enrollment. Initial enrollment must occur within twenty-four (24) months of an Eligible Person's arrival in the United States.

Coverage may be renewed, if available, and in the discretion of the Company, for additional periods at the premium rate in force at the time of renewal. The maximum total period of coverage for any one (1) Insured Person cannot exceed seven hundred and twenty-eight days (728) days or two (2) consecutive and continuous Policy Periods (the maximum length of each Policy Period is three hundred and sixty-four (364) days). Individuals who have their 70th birthday during their Policy Period will continue to be covered through their current Policy Period but will not be allowed to renew once that Policy Period expires. There is a $5 admin fee each time you renew, and renewal notices will be provided to you via e-mail. Additionally, the company may change aspects of the program, including rates, at any renewal date.

REFUND PROCEDURE

Seven Corners realizes that there is uncertainty in international travel. Refund of total plan cost will only be considered if written request is received by Seven Corners prior to the Effective Date of Coverage. If written request is received after the Effective Date of coverage, the unused portion of the plan cost may be refunded minus a cancellation fee, provided no claim has been submitted to Seven Corners for reimbursement.

GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1) Pre-Existing Conditions as defined herein. If you are a non-U.S. citizen under age 70, this exclusion is waived for eligible medical expenses for an Acute Onset of a Pre-existing Condition(s) (as defined herein) as shown in the Schedule of Benefits for your chosen plan (Plan A, B, C, and D). Benefits will be administered as stated in section F, Acute Onset of a Pre-Existing Condition(s), for eligible medical expenses incurred in the United States, minus your Deductible and subject to the scheduled limits for benefits as stated in the Schedule of Benefits. For persons age 70 and over, there is no benefit. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs, or treatments existent or necessary prior to the effective date of this program. Any exclusion specifically listed in General Exclusions and Limitations, numbers 2 through 44, as well as the section entitled Additional Limitations and Exclusions for Elective Surgery and Elective Treatment, will not receive benefits from this waiver;
2) Any loss that occurs while traveling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
3) Maximum benefit is reduced to $50,000 for any illness or injury occurring while on an incidental trip to the Insured Person's Home Country;
4) Routine physical, inoculations or other examinations including but not limited to laboratory, diagnostic, or x-ray examinations where there are no objective indications of impairment of normal health, or well baby care;
5) Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; eyeglasses, contact lenses; eye surgery when the primary purpose is to correct nearsightedness, farsightedness or astigmatism; or other treatment for visual defects and problems. "Visual Defects" means any physical defect of the eye which does or can impair normal vision;
6) Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing Defects" means any physical defect of the ear which does or can impair normal hearing;
7) Treatment and the provision of false teeth or dentures or dental appliances, normal ear tests and the provision of hearing aids, hearing implants, cosmetic or plastic Surgery (including deviated nasal septum), dental expenses except as specifically provided in the Dental Emergency Treatment benefit;
8) Services or supplies not necessary for the medical care of the patient's Injury or Sickness;
9) Weak, strained or flat feet, corns, calluses, or toenails;
10) Cosmetic surgery, or treatment for congenital anomalies (except as specifically provided), except reconstructive surgery as the result of a covered Injury or Sickness. Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness;
11) Elective surgery and elective treatment;
12) Treatment, drugs, diagnostic or surgical procedures in connection with infertility, impotency, artificial insemination, sterilization or reversal thereof, unless infertility is a result of a covered Injury or Sickness;
13) Birth control, including surgical procedures and devices;
14) Routine new-born baby care, well-baby nursery and related Physician charges;
15) Injury sustained while participating in professional, sponsored and/or organized Amateur or Interscholastic Athletics; including but not limited to the event, games, practice, conditioning and any other activity related to professional sponsored and/or organized Amateur of Interscholastic Athletics;
16) Injury sustained while taking part in Mountaineering, hang gliding, parachuting, bungee jumping, racing by any animal or motor vehicle or motorcycle, snowmobiling, motorcycle / motor scooter riding (whether as a passenger or driver), scuba diving involving underwater breathing apparatus (unless PADI or NAUI certified), water skiing, wakeboard riding, jet skiing, windsurfing, snow skiing and snowboarding and any other sport, recreational, athletic, or adventure activity which is undertaken for thrill seeking and exposes the insured to abnormal or extreme risk of injury and/or is in violation of applicable laws, rules, or regulations;
    Mountaineering shall mean the sport, hobby or profession of walking, hiking, and climbing up mountains either:
    1) utilizing harnesses, ropes, crampons or ice axes; or
    2) ascending 4500 meters or above.
17) Treatment paid for or furnished under any other individual, government, or group policy; previous policy; payable under any Worker's Compensation or Occupational Disease Law or Act; or charges provided at no cost to the Insured Person;
18) Occupational Diseases, including but not limited to Disease(s) related to asbestos exposure, and the complications thereof, including asbestosis and mesothelioma related to asbestos exposure;
19) Treatment for human organ or tissue transplants and their related treatment;
20) War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the Insured Person or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person whether war be declared with that state or not, Terrorist activity. For the purpose of this Exclusion; i) Terrorist activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s). ii) Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals. iii) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals. iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals. Also excluded hereon is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the situations described above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect;
21) Suicide or any attempt thereof, or self-destruction or any attempt thereof; intentionally self-inflicted Injury or Illness;
22) Charges of an institution, health service, or infirmary for whose service payment is not required in the absence of insurance;
23) Treatment of nervous or mental disorders, or Treatment in connection with alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency or use of any drug or narcotic agent; Injury sustained while under the influence of or Disablement due wholly or partly to the effects of intoxicating liquor, chemicals, or drugs or narcotic agent, unless administered under the advice of a Physician and said narcotic agent was taken in accordance with the proper dosing as directed by the physician; unless prescribed by a Physician, except as stated in the Schedule of Benefits for mental or nervous disorders;
24) Loss incurred from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
25) Treatment, services, supplies or facilities in a Hospital owned or operated by: a) the Veteran's Administration; or b) a national government or any of its agencies. (This exclusion does not apply to treatment when a charge is made which the Insured is required by law to pay);
26) Duplicate services actually provided by both a certified nurse-midwife and Physician;
27) Expenses payable under any prior policy which was in force for the person making the claim;
28) Expenses incurred during a Hospital emergency room visit which are not of an emergency nature;
29) Expenses incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;

30) Injury sustained as the result of the Insured operating a motor vehicle while not properly licensed to do so in the jurisdiction the motor vehicle accident occurs;
31) Voluntary or elective abortion;
32) Expenses covered by any other valid and collectible medical, health or accident insurance;
33) Expenses incurred after the date insurance terminates for an Insured Person except as may be specifically provided;
34) Treatment and or diagnosis of venereal disease , including all sexually transmitted diseases and conditions , and any and all consequences thereof;
35) Treatment(s) which is incurred by an Insured Person(s) who is HIV Positive (i.e., infected with the human immunodeficiency virus, the cause of acquired immunodeficiency syndrome) at the time of Application for this Insurance, whether or not the Insured Person(s) was asymptomatic or symptomatic or had knowledge of his/her HIV status on the initial Effective Date of Coverage, or any associated diagnostic tests or charges for HIV infection, seropositivity to the AIDS virus, AIDS related Illness(es), ARC Syndrome, AIDS, and all diseases caused by and/or related to HIV;
36) Treatment(s) for HIV, the AIDS virus, AIDS related Illness(es), ARC Syndrome, AIDS, and all diseases and illnesses caused by and/or related to HIV or arising as complications from these conditions including but not limited to the cost of testing for these conditions and/or charges for drug treatment(s) or surgeries;
37) Treatment for tuberculosis, malaria, cholera, dengue fever and parasitic-sourced illnesses, including but not limited to treatment required as a result of complications from those same diseases, whether or not previously manifested or symptomatic prior to the effective date of the Policy;
38) Charges incurred for treatment or surgeries which are Experimental / Investigational, or for research purposes; expenses which are non-medical in nature, expenses for custodial care, vocational, speech, recreational or music therapy, or durable medical equipment;
39) Expenses for services or supplies which are not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
40) Chiropractic care or complementary medicine including but not limited to acupuncture and massage;
41) Services, supplies, or treatment prescribed, performed or provided by a Relative of the Insured Person or any family member of the Insured Person or anyone who lives with the Insured Person. This includes but is not limited to prescription medication and any diagnostic testing;
42) Diagnosis or treatment of the Temporomandibular joint;
43) Treatment required as a result of complications or consequences of a treatment or for a condition not covered under this Policy;
44) Expenses for home health care, custodial care and/ or daily living, including but not limited to food, housing, or home maker services;
45) Expenses for environmental supplies, including but not limited to handrails, ramps, special telephones, air conditioners, or home delivered meals.
46) Pregnancy expenses or Sickness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from Injury;

ADDITIONAL LIMITATIONS AND EXCLUSIONS FOR ELECTIVE SURGERY AND ELECTIVE TREATMENT:

There are no benefits provided for the following: Elective surgery and elective treatment including but not limited to surgery and/or treatment for acne; acupuncture; allergy; including allergy testing; alopecia; biofeedback-type services; birth control; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the policy; family planning; fertility tests; gynecomatia; hirsutism; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nasal and sinus surgery; nicotine addiction; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); patient controlled anesthesia treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction, tubal ligation; vasectomy; and weight reduction. Elective surgery and elective treatment includes any service, treatment; or supplies that: 1) are deemed by the company to be researched or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

GENERAL PROVISIONS

1. **Entire Contract; Changes:** The Certificate, including the Application, Schedule of Benefits, endorsements and the attached papers, if any, constitutes the entire contract of Insurance. No change in the Certificate shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon. No agent has authority to change this Certificate or to waive any of its provisions;
2. **Notice of Claim:** Written notice of claim must be given to the Company within ninety (90) days after the occurrence or commencement of any Disablement covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.
3. **Claim Forms:** The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the Disablement for which claim is made.
4. **Proof of Loss:** Written Proof of Loss, which will include, but not limited to: original signed and dated claim form, original receipts and bills, copies of medical records; must be furnished to Seven Corners, at its said office, within ninety (90) days after the date of such Disablement. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In any case, the proof required must be given no later than one (1) year from the time specified except in the absence of legal capacity. The Company at its option may pend resolution and adjudication of submitted claims and/or deny coverage for Proof of Loss submitted thereafter, or for incomplete Proof of Loss and/or failure to submit Proof of Loss.
5. **Payment of Claims:** Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical or Surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services.
6. **Physical Examination and Autopsy:** The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. **Legal Actions:** Any disputes arising from this Certificate or its alleged breach may, if not resolved by the parties, be referred to arbitration by either party pursuant to the commercial arbitration rules of the American Arbitration Association ("AAA"). Either party may make a demand for arbitration and such arbitration shall be conducted in Carmel, Indiana, and judgment on any award rendered in such arbitration may be entered in any state or federal court in Indiana. Notices in connection with such arbitration and process in any judicial proceeding in connection wherewith may be served by personal delivery or registered mail on the Company at 303 Congressional Boulevard, Carmel, Indiana 46032 and on the Insured Person(s) at the most current address appearing in the records of the Company, with the same effect as if personally served in Carmel, Indiana.

   Arbitration shall be before a single arbitrator jointly selected by the parties hereto. If the parties are unable to agree on an arbitrator within thirty (30) days after the arbitration demand is filed, the AAA shall select the arbitrator. The arbitration filing fee, if any, and fees of the arbitrator shall initially be shared equally between the parties, provided however, that the prevailing party shall be reimbursed for these costs by the non-prevailing party at the conclusion of the arbitration proceeding. Each side shall bear their own legal fees and costs and any other fees associated with participating in the arbitration process. All fees and expenses of the arbitration shall be borne by the parties equally.

   The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one insured is involved in the same dispute arising out of the same Policy and relating to the same Loss or claim, all such Insured(s) will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insured(s) to assert several, rather than joint, claims or defenses.

   No actions at law or in equity shall be brought to recover on the Certificate prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after expiration of three (3) years after the time that written Proof of Loss is required to be furnished.

8. **Grace Period:** There is no Grace Period associated with this program.
9. **Cancellation:** The Certificate is renewable for up to a total period of three hundred and sixty-four (364) days. The Company may cancel an entire class of Insured Persons based upon claims experience in a certain region or within a gender / age category.
10. **Not in Lieu of Worker's Compensation:** This Insurance is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.
11. **Certificate of Insurance:** The Company shall issue to each Insured Person an individual Program Summary (Certificate of Insurance), which shall state the essential features of Insurance to which such person is entitled and to whom benefits are payable, if required to do so by the laws of the locality in which the Insured Person resides when his Insurance becomes effective.
12. **Data Furnished by Insured Person(s):** Insured Person shall furnish all information requested on the Application and any additional information requested by the Company.

    The refusal of the Insured Person, the Insured Person's Physician, Hospital or Service Provider to make all medical reports and records available to the Company could cause an otherwise valid claim or Application to be denied or the file to be closed due to lack of or limited reply from the Insured Person's medical providers.

    Failure on the part of the Insured Person to maintain adequate documentation regarding travel history could cause an otherwise valid claim (where travel history is material to the benefit and claim) to be denied or the file to be closed.

    The Company has the option whether or not to consider medical information provided by friends / relatives of the Insured Person as valid for underwriting or claim administration.
13. **Assignment:** The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance with #5, Payment of Claims.
14. **Excess Benefits:** All coverages shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.
    Other valid and collectible insurance for which benefits may be payable are insurance programs provided by:

    1.) Individual, group or blanket insurance or coverage;
    2.) Other prepayment coverage provided on a group or individual basis;
    3.) Any coverage under labor management trusteed plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other arrangement of benefits for individuals of a group;
    4.) Any coverage required or provided by any statute, socialized insurance program; or
    5.) Any no-fault automobile insurance;
    6.) Any third party liability insurance.
15. **Monetary Limits:** The monetary limits stated in this Certificate and the premium shall be in United States dollars. For services outside of the territorial limits of the United States, the exchange rate used to determine the amount of United States dollars to be paid is the exchange rate effective for the date the claims expense was incurred.
16. **Subrogation:** The Certificate has the right to full subrogation and reimbursement of any and all amounts paid by the Certificate to or on behalf of, an Insured Person, if the Insured person receives any sum of money from any person, plan or legal entity which is legally obligated to make payments arising out of any act or omission of any person whether a third party or another covered person under the Certificate, which directly or indirectly caused a physical or mental condition, in connection with which payment of any benefits under the Certificate to, or on behalf of, such Insured Person was made. The Certificate shall have a lien against such sum of money received from third parties or other persons described above or their insurers, or the insurer of the Insured Person, and shall be reimbursed therefrom. The Insured Person further agrees to notify other persons described above in writing, of the Certificate's subrogation and lien rights before the receipt of any payment from said parties or other persons.

    The Insured Person shall be responsible for all expenses of recovery from such parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such payments or payments by other persons, which fees and expenses shall not reduce the amount of reimbursement to the Certificate required of the Insured Person. The Insured Person agrees to reimburse the Certificate for any benefit paid hereunder, out of any monies recovered from such party or other persons as a result of judgment, settlement or otherwise, even though such monies are not characterized as amounts paid for medical expenses or claims. The Insured Person agrees to furnish such information and assistance, and to execute and deliver all necessary instruments, as the Company or its designee may request to facilitate the enforcement of these subrogation rights, including but not limited to the execution of a subrogation agreement prior to payments of benefits under the Certificate to, or on behalf of the Insured Person.

    The Insured Person shall not release or discharge any party from his or her obligation to the Insured Person or the Certificate or take any other action which could impair the Certificate's subrogation rights. The Certificate's exercise of its rights to take whatever action it sees fit against any third party or other persons shall not affect the Insured Person's right to pursue other forms of recovery.

    If the Insured Person or any one acting on his or her behalf has not taken action to push his or her rights against such parties or other persons to obtain a judgment, settlement or other recovery, the Company or its designee, upon giving thirty (30) days written notice to the Insured Person shall have the right to take such action in the name of the Insured Person to recover that amount of benefits paid under the Certificate; provided, however, that any action taken without the consent of the Insured Person shall be without prejudice to such Insured Person.

    The Certificate's right to reimbursement as set forth herein shall be payable first from sums received from the parties or other persons and such reimbursement shall continue until the Insured Person's obligations hereunder to the Certificate are fully discharges, even though the Insured Person does not receive full compensation or recovery for his/her injuries, damages loss or debt. This right to subrogation pro tanto shall exist in all cases.

    If an Insured Person fails to comply with these requirements, the Insured Person shall not be eligible to receive any benefits, services or payments under the Certificate until there is compliance regardless of whether such benefits are related to the act or omission of such party or other persons.
17. **Fraud and Misrepresentation:** Any misstatement, concealment or fraud in the Applicant's (or Applicant's authorized representative) statements, either on the Application or on subsequent contact (including any claim submissions), whether in writing or otherwise, to the Company or its representatives, shall render this insurance null and void and all claims hereunder shall be forfeited. In addition, if any fraudulent means or devices are used by any Insured Person (or Applicant) or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited.
18. **Patient Protection and Affordable Care Act:** This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include any additional benefits required by the PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent, or tax professional to determine if the PPACA's requirements are applicable to you.

Coverage Intent

Please be aware that this is not a general health insurance policy but an interim travel medical program intended for use while away from your Home Country or Country of Residence.

Pre-Notification

1. *Pre-Notification* - You or someone on Your behalf are required to contact Seven Corners Assist in the following situations:
   a) Within 48 hours of an emergency hospital admission anywhere in the world.
   b) Before a scheduled, non-emergency hospital admission anywhere in the world.
   c) Before receiving any medical treatment inside the United States.
   d) Before inpatient or outpatient surgery worldwide.

Pre-Notification does not guarantee that benefits will be paid.

Contact information for Seven Corners Assist is provided below and on the back of Your ID Card. Our multilingual representatives are available 24/7 to help you. Contact us immediately for Emergency Medical Evacuation, Return of Remains, Emergency Reunion, and Return of Minor Child(ren).

Seven Corners Assist
Inside the United States: 1-800-690-6295
Outside the United States: 0-317-818-2808 (Collect)
Fax: 1-317-815-5984
E-mail: assist@sevencorners.com

Wellabroad.com

In our ever changing world, Seven Corners' WellAbroad® seeks to prepare individuals and groups with the advanced tools for successful travel. WellAbroad® offers medical, political and cultural information and includes many benefits and educational resources, such as:

- Text messaging alerts - Registered users receive updates regarding weather emergencies, security issues, custom alerts, and health care or pandemic warnings.
- Online forums - Fellow travelers and Seven Corners' staff post experiences and travel tips which can be accessed at any time.

Claims Services

Important Note: Claim forms and receipts for medical expenses must be sent to Seven Corners quickly. Claim submissions must be made within ninety (90) after the Date of Service. Should they be received after ninety (90) days, they may be considered ineligible.

To report claims or verify eligibility, send the original bills and claim forms to Seven Corners, Inc., or call or fax to the numbers below. Be certain to include Your ID# shown on the ID Card with all correspondences:

Seven Corners, Inc.
303 Congressional Blvd; Carmel, IN 46032
800-335-0477 or 317-575-2256 FAX 317-575-2659 email: info@sevencorners.com www.Seven Corners.com

Insurance Company

This Insurance, under Policy LON15-150415-02TM, is underwritten by Certain Underwriters at Lloyds, London, rated A "Excellent" by AM Best.

SEVERABILITY OF INTEREST CLAUSE

This Policy shall operate in all respects as if a separate Policy had been issued to each party insured hereunder, except that in no event shall the total liability of the Insurers in respect of all parties insured hereunder exceed the Limit of Indemnity stated in this Policy. - **LSW1001**

LLOYD'S PRIVACY POLICY STATEMENT

UNDERWRITERS AT LLOYD'S, LONDON

The Certain Underwriters at Lloyd's, London want you to know how we protect the confidentiality of your non-public personal information. We want you to know how and why we use and disclose the information that we have about you. The following describes our policies and practices for securing the privacy of our current and former customers.

INFORMATION WE COLLECT

The non-public personal information that we collect about you includes, but is not limited to:
Information contained in applications or other forms that you submit to us, such as name, address, and social security number
Information about your transactions with our affiliates or other third-parties, such as balances and payment history
c) Information we receive from a consumer-reporting agency, such as credit-worthiness or credit history

INFORMATION WE DISCLOSE

We disclose the information that we have when it is necessary to provide our products and services. We may also disclose information when the law requires or permits us to do so,

CONFIDENTIALITY AND SECURITY

Only our employees and others who need the information to service your account have access to your personal information. We have measures in place to secure our paper files and computer systems.

RIGHT TO ACCESS OR CORRECT YOUR PERSONAL INFORMATION

You have a right to request access to or correction of your personal information that is in our possession.

CONTACTING US

If you have any questions about this privacy notice or would like to learn more about how we protect your privacy, please contact the agent or broker who handled this insurance. We can provide a more detailed statement of our privacy practices upon request. - **LSW1135b**

LLOYD'S

One Lime Street London EC3M &HA