



Purchasing Department

Coenen Hall 140 | 700 University Avenue | Monroe, LA 71209

P 318.342.5205 | F 318.342.5218

State of Louisiana
The University of Louisiana at Monroe
Monroe, La
A Member of the University Louisiana System

June 13, 2025

Addendum No.1

Bid #50006-41

Secondary Aggregate or Zero Deductible Insurance
Coverage for Student-Athletes and Other Participants or ULM Athletics Department

Due: June 25, 2025

The purpose of this addendum is to respond to questions submitted by potential bidders. The Bidder's questions are in bold print and are preceded by 'Q.' ULM's response are not bolded and are preceded by 'A'.

Q: 1. In section 3.2, the RFP references individuals to be covered by individual policies. Then, in section 3.4, the RFP states all student-athletes who are not participating in high-risk sports and who do not have an existing primary insurance policy will not have a primary plan purchased for them. It then goes on to state that the secondary insurance will act as primary for these student-athletes. Is the University looking for individual policies, and if so, what medical limits are you looking for?

A. No, ULM is not looking for individual policies.

Q: 2. Does the University purchase any individual plans for uninsured student-athletes? If so, how many and what plans are purchased?

A: No, ULM does not purchase individual plans for uninsured student athletes.

Q: 3. Does the University pay for any expenses directly or do they utilize the insurance company/third party administrator to pay all medical claims? If so, can you provide details on what the University pays for directly and how much has been paid each year over the prior 4 years?

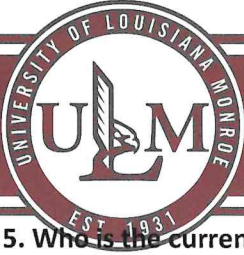
A: ULM does not make direct payments. The insurance company/third party makes payments on behalf of ULM.

Q: 4. Can you please provide a copy of current insurance policy?

A: Yes, please see attached.

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Q: 5. Who is the current insurance carrier for the current policy and prior 4 policy periods?

A: The current insurance carrier is Gallagher (2024-2025 and 2023-2024). ULM paid the medical bills from (2022-2023 and 2021-2022).

Q: 6. Can you please provide detail loss runs generated within the last month for the current and prior 4 policy periods?

A: Yes, please see attached for the last two years. Prior to 2023 ULM will not have a detailed report generated by an insurance carrier or claims payer.

Q: 7. Does your current broker take commission? (if so how much) or do they charge a fee (if so how much)?

A: Broker is currently compensated with a flat fee.

Q: 8. Can you please provide a list of your top medical providers?

A: North La Orthopedic & Sports, ACS of Northern Louisiana, St Francis Medical Center. FMOLHS Billing Services, Orthomed Staffing, Surgi-care Inc.

Q: 9. Do you have any contracts or arrangements in place with your medical providers (any sort of discount arrangements?) If so, can you summarize what those?

A: We do have an agreement with a local orthopedic group for services and discounted rates.

Q: 10. Are your international students-athletes required to purchase a specific plan when they come to the University of Louisiana at Monroe? If so, can you provide details on that plan?

A: No, they are not required.

Q: 11. Does your sports medicine department utilize injury tracking software? If so, who do they use and do they file claims electronically through their software currently?

A: Yes, ULM uses Teamworks. No claims are filed electronically.

Q: 12. Is the University of Louisiana at Monroe adding or removing any sports teams next year? If so, what is being added or removed?

A: No

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Q: 13. Has the University of Louisiana at Monroe added or removed any sports teams in the prior 4 policy periods? If so, can you please explain those changes?

A: No

Q: 14. Will ULM accept digital bid submission either via a bid website or via email?

A: No

Q: 15. Is ULM currently utilizing a primary insurance verification service? Is so, what is the cost?

A: No

Please acknowledge receipt of this addendum.

Authorize Signature: _____

Date: _____

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University of Louisiana-Monroe

Athletics Insurance Program

Plan Design and Loss Summary

Data as of: 6/10/2025

Intercollegiate Sports : Plan Design & Premium				
	2021	2022	2023	2024
Premium	\$ -	\$ -	\$ 30,000	\$ 30,000
Agg. Deductible	\$ -	\$ -	\$ 185,000	\$ 185,000
A-G Fee	\$ -	\$ -	\$ 14,000	\$ 14,000

Intercollegiate Sports : Deductible Claims Paid				
As Of	2021	2022	2023	2024
06/10/2024			37 \$ 94,433	
06/10/2025			63 \$ 185,000	72 \$ 185,000

Intercollegiate Sports : Insured Claims Paid				
As Of	2021	2022	2023	2024
06/10/2024			21 \$ 27,560	
06/10/2025			65 \$ 167,551	47 \$ 128,504

	2021	2022	2023	2024
Total Claims	\$0	\$0	\$352,551	\$313,504
Loss Ratio	-	-	559%	428%

Outside : Discretionary Payments				
As Of	2021	2022	2023	2024
06/10/2024	1 \$ 1,516	5 \$ 10,968	6 \$ 41,824	
06/10/2025	1 \$ 1,516	10 \$ 127,073	16 \$ 123,890	8 \$ 17,709

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER: University of Louisiana-Monroe
POLICY NUMBER: US2151570
POLICY EFFECTIVE DATE: July 1, 2024
POLICY EXPIRATION DATE: July 1, 2025

This Policy is issued in the state of Louisiana and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

10 DAY RIGHT TO RETURN THIS POLICY

If for any reason, you are not satisfied with this Policy, you may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this Policy will be deemed void, just as though it had never been issued.

THIS IS ACCIDENT ONLY COVERAGE.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS POLICY IS NOT RENEWABLE.

Signed for United States Fire Insurance Company By:



Marc J. Adey
Chairman and CEO



James Kraus
Secretary

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SCHEDULE OF BENEFITS

BENEFIT PERIOD: 104 weeks from the date of the Covered Injury.

AGGREGATE DEDUCTIBLE: \$185,000

CLASS OF ELIGIBLE PERSONS:

Class 1: All intercollegiate Student Athletes, Student Managers, Student Trainers, Student Coaches, and Graduate Assistants of the Policyholder. Policyholder Supervised and Sponsored intercollegiate play, practice, conditioning, off-season conditioning, and unauthorized team travel to and from events for the following sports:

Men's Baseball, Men's and Women's Basketball, Men's and Women's Cross Country, Men's Football, Men's and Women's Golf, Women's Sand Volleyball, Women's Soccer, Women's Softball, Women's Tennis, Men's and Women's Track & Field, and Women's Volleyball.

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum:	\$10,000
Aggregate Limit Amount:	\$1,000,000
Time Period for Loss:	104 Weeks

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum Amount per occurrence per Covered Person \$90,000

Disappearing Deductible: \$0

The Disappearing deductible must be satisfied before this plan will pay benefits. Amounts paid by other carriers will be used to satisfy the deductible under this plan. With a Disappearing Deductible, any amounts paid by other valid and collectible insurance toward the satisfaction of bills generated as a result of a covered accident will count toward satisfying the deductible. If the Covered Person's primary insurance makes any payment on an eligible expense, it counts toward the deductible, and amounts paid in excess of and applied to the deductible will cause the deductible to disappear or be reduced.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	100% of the Semi-Private Room Rate
Intensive Care Room & Board:	100% of URC
Hospital Miscellaneous Benefit:	100% of URC
Pre-Admission Testing Benefit:	100% of URC
In-Patient Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	100% of URC
Assistant Surgeon Benefit:	100% of URC
Out-Patient Surgery Benefits:	
Outpatient Primary Surgeons Maximum Benefit Amount:	100% of URC
Outpatient Assistant Surgeon	100% of URC
Outpatient Surgical Facility Maximum Benefit per	100% of URC
Emergency Room Benefit	100% of URC
Anesthesia Benefit:	100% of URC
Physician's Visits	
In-Hospital Maximum Benefit:	100% of URC
Office Visits (Out-of-Hospital) Maximum Benefit:	100% of URC
Maximum for All In-Hospital and Office Physician's Visits:	NA visits per injury
X-Ray Benefit	100% of URC
Laboratory Benefit	100% of URC
Nursing Benefit Amount:	100% of URC
Outpatient Physiotherapy Benefit	100% of URC
Maximum for All Physiotherapy:	100% of URC
Maximum Number of Visits per Covered Accident:	NA per Injury
Ground Ambulance Benefit Amount:	100% of URC

Dental Treatment For Injury Only
Benefit Amount:

100% URC

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any Accidental Death and Dismemberment benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

The total of all benefits payable under this Policy, including all Additional Accident Benefits paid for all Injuries caused by the same Covered Accident shall not exceed the Principal Sum indicated in the *Schedule of Benefits* unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

HEART OR CIRCULATORY MALFUNCTION BENEFIT **100% of URC**

EXPANDED MEDICAL TREATMENT BENEFIT **100% of URC**

RE-AGGRAVATION OF PRIOR SPORTS INJURY BENEFIT **100% of URC**

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

Benefit payable per prescription **100% of URC**

DURABLE MEDICAL EQUIPMENT BENEFIT **100% of URC**

HEAT EXHAUSTION BENEFIT **100% of URC**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Accident means a sudden, unforeseeable external event which:

1. Causes Injury to one or more Covered Persons; and
2. Occurs while coverage is in effect for the Covered Person.

Aircraft means a vehicle which:

1. Has a valid certificate of airworthiness; and
2. Is being flown by a pilot with a valid license appropriate to the aircraft.

Amateur means a sport or activity where the participants engage largely or entirely without compensation.

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Club means an organization of students formed for the purpose of engaging in competition in a particular sport or activity. Competition between student clubs from different colleges, not organized by and therefore not representing the institution or their faculties, may also be called "Intercollegiate" sports or activities.

Corridor Deductible means the dollar amount of the Covered Expenses the Insured person must pay towards the policy before We pay any benefits regardless of what any other Insurance Plan or other Insurance Carrier has paid. It applies separately for each Covered Person.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual, Reasonable and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and Certificate and which is performed or given under the direction of a Physician for treatment of an Injury. Coverage under the Policy and Certificate must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for a an Injury cannot be in excess of the maximum benefit amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Person means a person eligible for coverage as identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Policy.

Dependent means the Insured's unmarried child who:

1. Has his principal residence with the Insured;
2. Chiefly relies on the Insured for support and maintenance; and
3. Is within the following age groups (unless otherwise shown in the Application):
 - a. Under 21 years of age;
 - b. 21 but less than 25 years of age and enrolled in a School as a full time student; or
 - c. 21 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of intellectual or physical disability.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, natural child, and grandchild who is in the legal custody of and residing with the grandparent..

Disappearing Deductible means a dollar amount of Covered Expenses the Insured Covered Person must pay before We pay any benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance or Plan. The Disappearing Deductible is shown on the Schedule of Benefits.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Policy is in force.

He, his, and him includes she, her and hers.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or

7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Hospital means an institution which:

1. Is operated pursuant to law;
2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
3. Is under the supervision of a staff of Physicians;
4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
5. Has medical, diagnostic and treatment facilities, with major surgical facilities;
 - a. On its premises; or
 - b. Available to it on a prearranged basis; and
6. Charges for its services.
7. Is a duly licensed Rehabilitation Facility.

Hospital does not include:

1. A clinic or facility for:
 - a. Convalescent, custodial, educational or nursing care;
 - b. The aged, drug addicts or alcoholics;
2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
 - a. The services are rendered on an emergency basis; and
 - b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Interscholastic means a sport or activity organized between schools or representatives of the schools.

Intramural means a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from "within the walls" of an institution or area.

Immediate Family Member means the Covered Person's parent (includes step-parent), grandparent, Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

Leased Aircraft means an aircraft for which the Policyholder or any of its subsidiaries or affiliates has a written lease under whose terms, the aircraft:

1. Can be used at the Policyholder's or any of its subsidiaries' or affiliates' discretion;
2. Can be used by the Policyholder or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and
3. Cannot be altered or sold by the Policyholder or any of its subsidiaries or affiliates, without the consent of the leaser or owner.

Leased Aircraft does not include any Owned Aircraft.

Medically Necessary or Medical Necessity means a treatment, service or supply that is:

1. Required to treat an Injury; and
2. Prescribed or ordered by a Physician or furnished by a Hospital;

3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of alternative to be the Covered Expense.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Operated or Controlled Aircraft means an aircraft which:

1. Has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days, or more than 15 days in any one year;
2. Can be used at the Policyholder's discretion; and
3. Cannot be altered or sold by the Policyholder without the consent of the owner or leaser.

Operated or Controlled Aircraft does not include any Owned Aircraft.

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether Insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Any amount payable for Hospital, medical or other health services for Accidental bodily Injury arising out of a motor vehicle Accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for that settlement.
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he or she becomes disabled while Insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Owned Aircraft means aircraft to which the Policyholder or any of its subsidiaries or affiliates holds legal or equitable title.

Physician means a person who is a qualified practitioner of medicine. A such, He or She must be acting within the scope of his/her license and under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's Spouse, son, daughter, father, mother, brother, or sister or other relative.

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

School means the participating School or School District where the Covered Person is enrolled or employed. The School must be a duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate School.

Spouse means the lawful Spouse, if not legally separated or divorced, or Domestic Partner or Civil Partner.

Student Infirmary means an on campus facility which:

1. Provides medical care and treatment to sick and injured students and faculty;
2. Is under the supervision of a Physician;
3. Provides nursing services; and
4. Charges for its services.

Student Infirmary does not include:

1. Medical, diagnostic or treatment facilities with major surgical facilities:
 - a. On its premises; or
 - b. Available to it on a prearranged basis; or
2. In-patient care.

(No benefits are payable for services, supplies, or treatment in a Student Infirmary. This definition is applicable only to its reference in the provision titled Additional Exclusions.)

Supervised or Sponsored Activity means a Policyholder or School authorized function:

1. In which the Covered Person participates;
 2. Which is organized by or under its auspices;
- which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

Usual, Reasonable and Customary means:

1. With respect to fees or charges, fees for medical services or supplies which are:
 - a. Usually charged by the provider for the service or supply given; and
 - b. The average charged for the service or supply in the locality in which the service or supply is received; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

Waiting Period means the length of time from the date of loss to the time when benefits can be received.

ELIGIBILITY FOR INSURANCE

Eligibility:

Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Application. This includes anyone who may become eligible while this Policy is in force.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date: The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date: A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:

1. The Effective Date of the Policy; or
2. The day He becomes eligible, subject to any required waiting period, according to the referenced date shown in the Application/Enrollment Form.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

1. The Policy Termination Date shown in the Policy; or
2. The premium due date if premiums are not paid when due subject to any grace period.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 60 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination:

Insurance for a Covered Person will end on the earliest of:

1. The date he is no longer in an Eligible Class.
2. The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a. The date the premium is fully earned; or
 - b. The Expiration Date of this Policy.This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated.

Covered Person's Termination Date

Insurance for a Covered Person will end on the earliest of:

1. The date He is no longer in an Eligible Class.
2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a. The date the premium is fully earned; or
 - b. The Expiration Date of this Policy.This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated; or
5. The date the Covered Person requests, in writing, that his/her coverage be terminated.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which:

1. Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under this Policy; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Full Excess Medical Expense:

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:

1. While the person is insured under this Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS: and

1. Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
2. Subject to compliance with the requirement, set forth in the Limitations section of this Policy.

HMO/PPO PROVISION

In the event that Covered Expenses are denied under a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or other group medical plan the Covered Person has in force, and such denial is because care or treatment was received outside of the network's geographic area, benefits will be payable under this coverage, provided the expense is a Covered Expense.

DESCRIPTION OF HAZARDS

HAZARD: SPORTS COVERAGE

Subject to all other provisions of this Policy, coverage is provided for a Covered Person while he is:

1. Taking part in:
 - a. A regularly scheduled athletic game or competition; or
 - b. A practice session for an athletic team or club;
2. Traveling to or from such a game, competition or practice session provided he is:
 - a. Traveling with the athletic team or club; and
 - b. Under the direct and immediate supervision of:
 - i. The athletic team or club; or
 - ii. An adult authorized by the athletic team or club; or
3. Traveling directly, without interruption
 - a. Between his home and a scheduled game, competition or practice session;
 - b. In a vehicle which is
 - i. Designated or furnished by the athletic team or club;
 - ii. Operated by a properly licensed, adult driver; or
 - iii. Under the direct supervision of the athletic team or club; or
 - c. In a vehicle other than that described in 3.b. when:
 - i. Operated by a properly licensed driver; and

Travel time includes the time:

- i. To or from home, a scheduled game, competition or practice session;
- ii. Before required attendance time;
- iii. After the Covered Person is dismissed; and
- iv. After the Covered Person completes extra duties assigned by the School.

Covered athletic games or competition are shown on the Schedule of Benefits.

Injuries which result over a period of time (such as blisters, tennis elbow, etc.), and which are a normal, foreseeable result of the sport, are not covered.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH DISMEMBERMENT

If, within 1 year from the date of an Accident covered by this Policy, Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

<u>Loss</u>	<u>Percentage of Principal Sum</u>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL and DENTAL EXPENSE BENEFITS

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Benefit Periods, benefit maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 180 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses:** charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2. **Intensive Care Room and Board** - charges for each day of Intensive Care Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.
3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.
4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)
5. **In-Patient Surgical Benefits** - charges for:
 - a. A Physician, for primary performance of a surgical procedure, up to the maximum benefit amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
 - b. A Physician, for: assistant surgeon duties up to the maximum benefit shown in the Schedule of Benefits for an Assistant Surgeon.

6. **Out-Patient Surgery Benefits:**

We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

- a. necessary for treatment of the Covered Person; and
- b. given in the outpatient department of a Hospital or an ambulatory surgical center.

7. **Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.

8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:

- a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.
- b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

10. **X-Ray Benefit** - We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x -ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

11. **Laboratory Benefit**- We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.

13. **Physiotherapy** - Charges for physiotherapy:
- a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

Total treatment per Injury will not exceed the maximum benefit amounts for Physiotherapy shown in the Schedule of Benefits.

14. **Air & Ground Ambulance** - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.
- Ground Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the injured from the scene of the Accident to a Hospital. Surface trips must be to the closest local facility that can provided the covered service appropriate to the condition. If there is no such local facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the injured to the closest local facility available, coverage is for trips to the closest facility outside the local area.
15. **Dental Treatment for Injury Only** - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the maximum benefit amount shown in the Schedule of Benefits for the Dental Treatment benefit.

ADDITIONAL ACCIDENT BENEFITS

HEART OR CIRCULATORY MALFUNCTION BENEFIT

We will pay benefits for a Covered Person who suffers a sudden Heart or Circulatory Malfunction that results directly and independently of all other causes, from a Covered Accident and the first symptoms of the malfunction are medically diagnosed while the Covered Person is covered under this Policy and within 48 hours of a Covered Accident.

Benefits will not be payable if in the past year, the Covered Person was medically diagnosed as having, or received treatment for:

1. a heart or circulatory malfunction; or
2. hypertension, angina or other heart or circulatory condition.

Benefits will not be payable if the Covered Person is diagnosed with a newly diagnosed congenital disorder.

Symptoms, such as shortness of breath, heart pain or numbness of a limb are covered during the first 48 hours. These symptoms are not covered beyond the first 48 hours unless:

1. they first occurred within 48 hours; and
2. an actual malfunction of the heart or circulatory system is subsequently diagnosed.

EXPANDED MEDICAL TREATMENT BENEFIT

Benefits will be payable on the same basis as any other Injury for treatment of the following conditions resulting from the play or practice of Intercollegiate Sports: Repetitive Motion Injuries; Strains; Sprains; Hernia; Tennis Elbow; Tendonitis; Bursitis; and Muscle tears. Benefits are subject to the same limitations, and Deductible as any other Injury.

RE-AGGRAVATION OF PRIOR SPORTS INJURY

During play or practice of intercollegiate sports, benefits are payable for re-aggravation of a sports Injury suffered prior to the Effective Date of a **covered person's** coverage under the Policy. For the purposes of this Re-aggravation of Prior Sports Injury benefit only, such re-aggravation will be considered an **Injury** if the re-injury occurs under circumstances which would have otherwise been covered under the Policy. Any exclusion for congenital conditions, sickness, or disease remains in force.

The maximum amount payable under this Re-aggravation of Prior Sports Injury benefit is limited to the amount shown on the Schedule of Benefits. This amount is included in the Aggregate Maximum Benefit Amount, per **covered person**, per accidental **injury**, as shown on the Schedule of Benefits, and is not in addition to that amount.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses- shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

1. Under Federal law may only be dispensed by written prescription; and
2. Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:

1. On or after the Covered Person's Effective Date; and
2. By a licensed pharmacy provider.

Benefits are payable up to the maximum benefit amount shown on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT BENEFIT

We will pay the benefit shown in the Schedule of Benefits if, by reason of Injury, a Covered Person requires the use of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:

1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. can withstand long-term repeated use without replacement;
3. is not useful in the absence of the Covered Injury and
4. can be used in the home without medical supervision; and
5. the purpose of the equipment is not to help the Covered Person participate in sports activity.

HEAT EXHAUSTION

We will pay the benefit amount shown in the Schedule of Benefits for Heat Exhaustion as the result of a Covered Accident.

Heat Exhaustion means a condition characterized by faintness, rapid pulse, nausea, profuse sweating, cool skin, and collapse, caused by prolonged exposure to heat accompanied by loss of adequate fluid and salt from the body.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Participation in a riot or insurrection.
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling, assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or nervous disorders.
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
12. Intoxication or being under the influence of any drug or narcotic.
13. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
15. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
16. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
17. Conditions that are not caused by a Covered Accident.
18. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
19. Any treatment, service or supply not specifically covered by this Policy.
20. Loss resulting from participation in any activity not specifically covered by this Policy.
21. Charges which Are in excess of Usual, Reasonable and Customary charges.
22. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
23. Regular health check ups.
24. Services or treatment rendered by a Physician, Nurse, or any other person who is employed or retained by the Policyholder.
25. Services or treatment rendered by an Immediate Family member of the Covered Person;
26. Injuries paid under Workers' Compensation, Employers liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
27. That part of the medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited).
28. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
29. Travel or activity outside the United States.
30. Participation in any motorized race or speed contest.
31. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
32. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.

33. Expense incurred for treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy; or craniomandibular joint dysfunction and associated myofascial pain, except as specifically provided in this Policy.
34. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident..
35. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore.
36. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
37. Travel in or upon:
 - a. A snowmobile;
 - b. A water jet ski;
 - c. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
 - d. Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation competition.
38. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b. While being used for any test or experimental purpose; or
 - c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
 - d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
 - e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f. an ultralight hang-gliding, parachuting, or bungi-cord jumping
 Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
39. Treatment for an Injury that is caused by or results from a nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
 - a. The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy and
 - b. The Covered Person was within a 25-mile radius of the site of release either:
 - i. At the time of the release; or
 - ii. Within 24 hours of the start of the release
40. The repair or replacement of existing artificial limbs, orthopedic braces or orthotic devices.
41. Rest cures or custodial care.
42. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
43. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

LIMITATIONS

Any benefits payable under this Certificate will be limited to the following:

- (1) The medical benefits otherwise payable under this Certificate will be reduced by 50% if:
 - (a) Excess insurance is provided under this Certificate; and
 - (b) The Covered Person has coverage under another plan providing medical expense benefits; and
 - (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and

- (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) In the event no consenting surgical opinion is obtained for those procedures that mandate such second surgical opinion benefits payable for all Eligible Expenses associated with the procedure will be reduced by 50%. This limitation will apply whether the surgery is performed on an in-patient or out-patient basis. We will not cover a second opinion given more than 6 months after surgery was first recommended.

(3) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:

- (a) Medically necessary for the care or treatment of a covered Injury;
- (b) Received while coverage is in force under this Certificate; and
- (c) Rendered and/or prescribed by a licensed Physician other than the Covered Person or a member of his household or immediate family) in accordance with current medical standards and practices.

(4) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(5) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

AGGREGATE LIMIT

The Aggregate Limit Amount is shown in the Application. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

PREMIUM PROVISIONS

GRACE PERIOD:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:

Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:

We have the right to change the premium rates on any premium due date:

- 1. After the first 12 months insurance is in effect;
- 2. Coinciding with a change in the coverage provided or classes eligible; or
- 3. Coinciding with a change in the risks we have assumed.

We will give 45 days written notice of any change under 1. above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under this Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under this Policy. Examination may occur at any reasonable time up to the later of:

1. The two year period after the expiration of the Policyholder's coverage; or
2. The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

1. The names of all persons insured on the Effective Date of this Policy;
2. The names of all persons who are insured after the Effective Date of this Policy;
3. The names of those persons whose insurance has terminated; and
4. Additional information required as agreed to by us and the Policyholder.

NEWLY ACQUIRED SUBSIDIARIES:

The premium for this Policy applies to the risks assumed on the Effective Date of this Policy. Eligible employees or members of subsidiaries newly acquired through merger, stock purchase, exchange of stock, or otherwise, shall be insured under this Policy, subject to the following conditions:

1. The Policyholder has at least 50% controlling interest in the subsidiary.
2. An additional premium payment is required with a report to us and the name of any newly acquired subsidiary.
3. Necessary underwriting information must be furnished for us to determine the additional risks assumed.
4. Coverage will begin on the legal date of acquisition.

No coverage shall continue for more than 60 days after the legal acquisition date unless the required report with the necessary data is supplied and the additional premium paid. The Policyholder shall be liable for payment of premium for the period during which such coverage remains in effect.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:

Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice must be given to us within **30** days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:

When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:

Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid within 30 days upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:

Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;

2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:

All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY: (Applicable only if an Accidental Death or Dismemberment benefit is provided)

The Insured can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:

If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:

1. The Covered Person first agrees in writing to refund the lesser of:
 - a. The amount we actually paid for such expenses; or
 - b. The amount actually received from the third party for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

PHYSICAL EXAMINATION AND AUTOPSY:

We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits we have paid to him for injuries:

1. Received in a covered Accident; and
2. Which are covered under:
 - a. workers' compensation or similar statutory remedies available under law; or
 - b. Any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

SUBROGATION:

If we have paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of

the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

LEGAL ACTIONS:

No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

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

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

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY:

Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Claim Form: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

NEW YORK*: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature _____ Date _____

*The fraud warning in NY must appear above the signature line.

When used throughout this document "The Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form 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. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey 07724

Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association, if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contract holder;
- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) Medicare Part C benefits or Medicare Part D benefits;
- (8) certain unallocated annuity contracts (which give rights to group contract holders, not individuals) and certain structured settlement annuity contracts;
- (9) Other exceptions and exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Association Law, Louisiana Revised Statutes R.S. 22:2081 *et seq.*

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$500,000 limit, the Association will not pay more than: \$500,000 in health insurance benefits; \$250,000 in present value of annuities (including cash surrender and cash withdrawal values); or \$300,000 in life insurance death benefits (but not more than \$100,000 in cash surrender and cash withdrawal values) - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

Effective Date: August 1, 2014

When used throughout this document “Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A “**Grievance**” is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An “**Adverse Determination**” is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

Grievance

- (1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
- (2) A statement of the reviewer's understanding of the Grievance.
- (3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
- (4) A reference to the evidence or documentation used as the basis for the decision.
- (5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
- (6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

- (1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
- (2) a statement of your rights, including the right to:
 - attend the Second Level Review
 - present his/her case to the review panel;
 - submit supporting materials before and at the review meeting;
 - ask questions of any member of the review panel;
 - be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
 - request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

- (1) were not previously involved in any matter giving rise to the Second Level Review;
- (2) are not employees of the Company or Utilization Review Organization; and
- (3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

- (1) the name(s), title(s) and qualifying credentials of the members of the review panel;
- (2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
- (3) the review panel's recommendation to the Company and the rationale behind the recommendation;

Grievance

- (4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
- (5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
- (6) the rationale for the Company's decision if it differs from the review panel's recommendation;
- (7) a statement that the decision is the Company's final determination in the matter;
- (8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.



Re: Add Change Form

From Beverly Word <word@ulm.edu>
Date Wed 6/11/2025 3:12 PM
To Angie Hutchinson <hutchinson@ulm.edu>

Good afternoon, Angie. I wanted to circle back to you in regard to the Change Order for P0031253. I never received the original - only the copy that you sent me via email on May 28. I am required to process Change Orders from a fully approved original only. Is there any chance that the original may still be in your department for approval signatures? If you can check this for me, it would help me to know when I might expect to receive it. Hopefully, we can get it accounted for and routed to me soon.

Thanks in advance for checking on this.

Regards,
Beverly

From: Beverly Word <word@ulm.edu>
Sent: Wednesday, May 28, 2025 8:33 AM
To: Angie Hutchinson <hutchinson@ulm.edu>
Subject: Re: Add Change Form

Good morning, Angie. Thanks for sending this over. I will be watching for the original to come to me after it has been routed for approval signatures. I may have questions when I get ready to process it.

Thanks,
Beverly

From: Angie Hutchinson <hutchinson@ulm.edu>
Sent: Wednesday, May 28, 2025 8:16 AM
To: Beverly Word <word@ulm.edu>
Subject: Add Change Form

Good morning,

Attached is the add/change form for ATI to adjust amount due

Thanks,



Angie Hutchinson
Busn & Facil Mgr Health Sci | College of Health Sciences
hutchinson@ulm.edu
HANN 241-F | 700 University Ave., Monroe, LA 71209