
CORPORATE
EMPLOYERS
CARE
ACCIDENT
RESPONSIBLE

HIGHLIGHTS

- Twelve Month Rate Guarantee
- Combined Limit for all benefits including Weekly Accident Indemnity; Accident Medical; Accidental Death and Dismemberment; and Loss of Use (or Total Permanent Disability.)
- Availability of a PPO (not required)
- Limits up to $1,000,000
- Deductibles as low as $500
- Benefit Period of 1, 2 or 3 years
- Rates based on: percentage of payroll or per person
- Available to Groups with 2 + Lives
- Low Minimum Premium - $50 a month

DISCLAIMER

THE POLICY DESCRIBED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES CERTAIN COMMON-LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE BE AVAILABLE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKER'S' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CORPORATE ACCIDENT for RESPONSIBLE EMPLOYERS

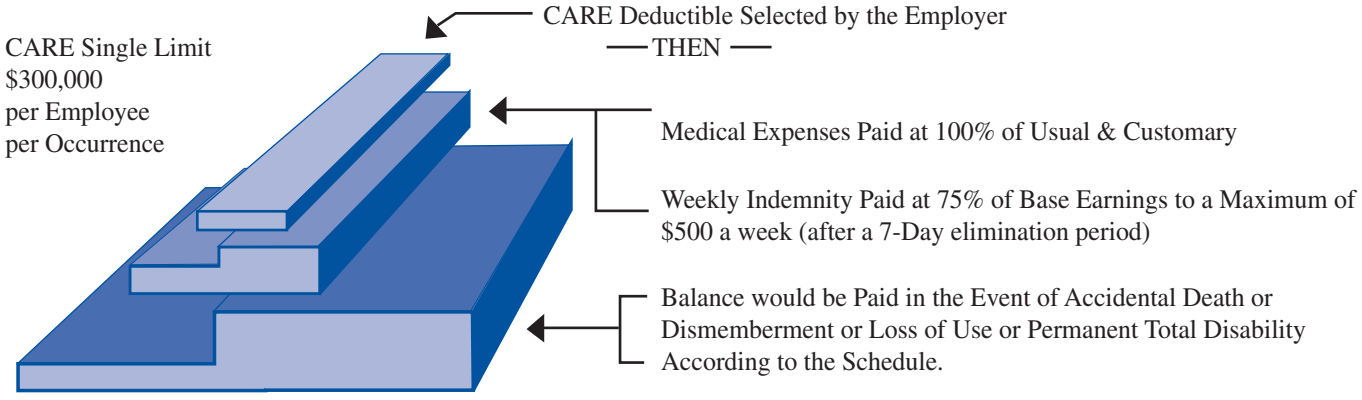
Over the past few years, the use of accident insurance plans to provide coverage for employees injured on the job has greatly increased, and the forms, rating approach, and benefits available have changed to meet the demands of the employer. Corporate Accident for Responsible Employers is the newest in the evolution of products to give employers choices in funding for coverage of accidental injuries on the job.

The plan is designed to be used as a stand alone accident program to allow the employer to budget its costs properly. The employer can select the CARE benefit that best fits its needs. There is a single limit and deductible for all benefits avoiding the necessity to try to determine what would be appropriate for each. All benefits are available to meet the expenses where necessary.

The plan is not designed as a substitute for workers' compensation and the employer should be aware of the differences before choosing any accident program.

OPERATION OF THE PLAN

Coverage will be provided, subject to the limits of the contract, for employees suffering a covered loss where the amount of the loss exceeds the deductible up to the single CARE limit selected. A $300,000 limit will provide up to that amount in medical expenses or a combination of accident medical, disability or death and dismemberment benefits. Some internal limits apply but the plan provides benefits where it is necessary. The employee gets to use the full coverage to pay for the losses sustained; therefore, the employer is not purchasing benefits employees will not use.



PREFERRED PROVIDER ORGANIZATION

We have contracted with a PPO Network so that in the event an employee uses one of the participating medical providers, the bill will be repriced. This only occurs if we receive the bill prior to any payment.

The employer wins, when employees use contracted providers, because the overall cost of the program is decreased and the employee still receives care from qualified professionals.

SINGLE LIMIT—Per Employee, Per Occurrence

- Deductible can be from a minimum $500 to $100,000
- Single Limit can be as low as $100,000 or as high as $1,000,000
- The Benefit Period is either 52, 104, or 156 weeks long

DESCRIPTION OF COVERAGE

Amounts paid for all benefits as the result of one injury shall not exceed the CARE Single Limit

Accidental Death & Dismemberment Benefit

If, while covered under this policy, an employee suffers one of the following losses, within the benefit period (365 or 730 days) as the result of a covered accident t he Company will pay the appropriate corresponding benefit:

Loss of	**Benefit**
Life	The Principal Sum*
Both Hands or Both Feet	The Principal Sum*
Speech and Hearing in Both Ears	The Principal Sum*
Sight of Both Eyes	The Principal Sum*
One Hand and One Foot	The Principal Sum*
One Hand and Sight of One Eye	The Principal Sum*
One Foot and Sight of One Eye	The Principal Sum*
One Hand or One Foot	1/2 The Principal Sum*
Speech or Hearing in Both Ears	1/2 The Principal Sum*
Sight of One Eye	1/2 The Principal Sum*
Thumb and Index Finger (same hand)	1/4 The Principal Sum*
Loss of Use of:	
Both Arms and Both Legs	The Principal Sum*
Both Arms or Both Legs	3/4 The Principal Sum*
One Arm and One Leg	3/4 The Principal Sum*
One Arm or One Leg	1/2 The Principal Sum*

"Loss" when used in reference to: hand means the actual, permanent and complete severance of all four fingers or the complete severance through or above the wrist joint; foot means the actual, permanent and complete severance through or above the ankle joint; sight means the total and irrecoverable loss of sight: speech or hearing means the complete and irrecoverable loss of that function; thumb and index finger means the complete severance through or above the metacarpophalangeal joints.

"Loss of Use" means the total loss of movement or total feeling in the arm (including the hand) and/or leg (including the foot) as determined by a physician to be complete and irrecoverable.

*The Principal Sum reduces at age 70.

Permanent and Total Disability

(If this benefit is selected, the Loss of Use schedule above is deleted.) An employer can select this benefit instead of the Loss of Use benefit explained above. If the employer selects the Permanent and Total Disability Benefit and an employee suffers a loss as the result of a covered accident, the Company will pay 1.66% of the Principal Sum for a maximum of 60 months. The payment will begin after all Weekly Accident Indemnity Benefits have been paid or 12 months after the date of the accident, whichever is later.

"Permanent and Total Disability (PTD)" means the inability of the employee to perform any occupation for wage or profit for which he/she is trained, educated or has the background to perform. The PTD must begin within 180 days of the date of the accident and be determined by a physician. The employee must be under the continued care of a physician and the employee must have been permanently and totally disabled consecutively for at least 6 months (12 months for the 104 or 156 week benefit period).

THE TOTAL AMOUNT PAYABLE TO ANY ONE EMPLOYEE FOR ANY ACCIDENT SHALL NOT BE MORE THAN THE PRINCIPAL SUM.

The Principal Sum is equal to the CARE Single Limit; however, for any one employee the Principal Sum **cannot** exceed ten (10) times the employee's annual base salary.

ACCIDENTAL BODILY INJURY or INJURY means an Injury suffered by the Insured which is the direct result of an accident which occurs while the Insured's coverage under this Policy is in force. The Injury must be involuntary and direct and independent of all other causes. The Injury must result directly from any of the covered Hazards described in the policy

Annual Base Salary: for non-commissioned employees is the amount of compensation to an employee from the employer, excluding overtime, bonus or commissions; and for commissioned employees, it is the average annual earning over the past 3 years; for employees with less than 3 years history with the employer, an average monthly earning will be calculated and multiplied by 12.

In the event an employee suffers a covered Accidental Death the minimum Principal Sum capitalize sum is 15% of the CARE Single Limit and will be paid regardless of any other amounts paid under the policy.

Primary Accident Medical Benefit

If while covered under the policy, an employee suffers covered losses requiring hospital, surgical or medical treatment, the Company will pay for those expenses that are medically necessary and do not exceed the reasonable and customary limits in the geographical area where the treatment is rendered. The employee must be under the care of a physician

Expenses shall be considered covered if the first charge occurs within 30 days of the date of the accident and are incurred within the benefit period selected by the employer.

Weekly Accident Indemnity Benefit

If an employee becomes totally disabled within 30 days of a covered accident, the Company will pay the lesser of: *a*) 75% of the employee's Base Weekly Salary; *b*) a maximum weekly benefit of $500; *c*) 85% of base weekly salary reduced by any post disability earnings; or *d*) 125% of the lesser of *a*) or *b*) above reduced by any post disability earnings. This benefit is payable after the employee has been disabled for seven consecutive days as verified by the employee's attending physician for as long as the employee is totally disabled (and not active at work), but not to exceed the selected benefit period.

"Base Weekly Salary" is the employee's Annual Base Salary divided by 52.

"Total Disability" means the employee is unable to perform all the material duties of his/her occupation.

Order of Benefit Payments

If more than one benefit is payable under the policy, the Company will pay the benefits in the following order according to the date the Company receives written notice that an employee incurred a covered loss: Accidental Medical Expense, Weekly Accidental Indemnity, Accidental Dismemberment Accidental Death, Permanent and Total Disability

If the Company is unable to determine the order of benefit payment, the Company reserves the sole right to determine any other order of benefit payment without any prejudices to the employee or any beneficiary.

Aggregate Limit of Liability for Common Accidents

The maximum policy amount for all losses to all insured employees resulting from one accident shall not exceed the lesser of $2,000,000 or ten (10) times the CARE Single Limit. Requests for other limits will be considered.

Plan Exclusions

This Policy does not cover any loss caused by or resulting from:

1) suicide or any attempt at suicide or intentionally self-inflicted injury, while sane or insane;

2) committing or attempting to commit an assault or felony;

3) war or act of war whether declared or not;

4) disease, sickness, bodily or mental infirmity, and medical or surgical treatment for any of these;

5) ptomaine or bacterial infection, other than bacterial infection occurring in consequence of a covered accidental cut or wound;

6) participation in the military, naval or air forces of any country;

7) participation in a riot, rebellion or insurrection of any act or any incident to any of these. For purposes of this exclusion, "participation" means to take an active part in common with other; "riot" means any use of or the threat to use force or violence by three or more persons without the authority of law;

8) with regard to aircraft (unless We have agreed in writing to cover any of the hazards listed in a) through d) below:

   a) boarding, alighting from, or being on any aircraft owned, operated or leased by the Policyholder, the Insured, or a member of the Insured's household;

   b) flying in any aircraft which is rocket propelled;

   c) flying in any aircraft being used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration, pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting, or any test or experimental purpose;

   d) flying when a special permit or waiver from the proper authority has to be issued;

9) any accidental bodily injury that occurs while an Insured has been determined to be legally intoxicated, under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless administered on the advice of a Physician and is taken according to the prescribed dosage, when the use of such substance was approximate cause of the Accidental Bodily Injury.

For medical benefits only, no coverage is provided for experimental or custodial treatment, or for personal comfort items such as use of telephone or television.

ADMINISTRATION

Employer Contribution

Our program is designed for employers who desire to provide these coverages as an employee benefit plan; therefore we require 100% of the cost to be paid by the employer. All employees must participate.

New Employees

All employees are covered as of the date they become active at their jobs. No waiting period is required.

Employee Termination

Coverage for an employee stops as soon as he/she is no longer an active employee.

Policy Termination and Renewal

The Policy remains in effect until its Expiration Date, subject to the required premium being paid. The Company can extend the policy by giving the policyholder written confirmation of such extension.

Premium Payments

Premiums are due on the monthly due date. Calculations should be made based on payroll for last complete payroll month. Accounts not paid by the 31st day after the premium due date will lapse for non-payment of premium.

Also available, when approved by our underwriter, are level premium installments. When paying with a level premium installment, the Client has the option of paying a level premium on a monthly, or annual basis. In order to do this we would need annual payroll reports to calculate the payments, and the account would be audited on an annual basis. Once the audit is complete, any additional premium would be due at that time. If the audit reveals too much premium was paid, it would not be refunded as the level payments are minimum deposit payments.

UNDERWRITING RULES

We are very flexible in our underwriting of risks for CARE; however, as with all insurance products, we adhere to certain guidelines. Each rating class can have a different benefit, provided rating Class A employees have a higher or equal benefit as rating Class B employees; rating Class B employees have a higher or equal benefit to rating Class C employees, etc. For example: if rating Class C had a $300,000 benefit, rating Class D could not have a greater benefit, but Classes A & B could have higher benefits. The rating classes are subject to the approval of the underwriting department.

Please submit your request for coverage five days prior to the desired effective date with the following information:

- Certification by Policyholder;
- First month's premium check payable to Fidelity Security Life Insurance Company;
- Three years claims experience for groups of 50+ lives or that contain class "F" (must be quoted by Home Office);
- Completed Information Sheet;
- Completed Census Information Form;
- Completed Single Case Commission Agreement;
- Product Information Disclaimer signed by the agent.

You will be notified when your case has been approved and when the coverage is effective. This process takes from 5 to 7 business days as we may require further information from you or your client. Once approved, we will send you a policy for delivery along with an application to be signed and returned by the Policyholder. As soon as the case is approved, the premium reporting forms will be sent directly to your client.

Do not cancel any existing coverage until your group has been accepted for coverage.

SPECIAL QUOTATION INFORMATION REQUIREMENTS

To receive a CARE quotation on groups that fall outside the brochure program, please be sure you supply us or your General Agent with:

- actual name and address of the group;
- the nature of business;
- the total number of employees currently on payroll or being reported to the State Employment Commission. Please break the total employee count down by class;
- the applicable occupational code, or a complete detailed job description of each employee (please remember job titles are not job descriptions);
- the estimated monthly payroll*, broken down by occupational code if available;
- the past three years claims experience under any occupational injury plan, indicating whether the plan covered accidents only, or accident and occupational diseases. The more detailed the experience, the better underwriting we will be able to do. Include the number of claims involved, the amounts filed, the amounts paid and pending (if possible separate death, disability, and medical losses.)

* When supplying the estimated monthly payroll, please calculate the monthly salaries of hourly paid employees by figuring their weekly salary and multiplying by "4.30". For each hourly paid employee, you MUST denote the number of hours per week you have used to figure the weekly salary. When this information is not provided, we will assume that all employees work a 40 hour week, which may adversely affect our quotation.

CERTIFICATION BY POLICYHOLDER

We, _____, do hereby certify the following:

1. We have applied to the companies listed below for the coverages listed and fully understand the insurance applied for shall not be effective until the application is approved and accepted by the Company and a Contract is issued. No agent has the authority to bind coverage.

Insurance Company	Coverage Applied For

2. We have reviewed, with the agent of the company whose signature appears below, the coverages, limits, terms, and exclusions of each contract.

3. We understand each of the following:

   a. This is not Workers' Compensation Insurance.

   b. **Excess Reimbursement** coverage is a reimbursement contract for certain benefits paid by us under the terms of our Employee Benefit Plan subject to the Employee Retirement Income Security Act (ERISA) or the deductible portion of our workers' compensation policy. The insurance carrier is not authorized to and does not sell workers' compensation insurance.

   c. **Employers Excess Indemnity and/or Limited Employers Indemnity** coverage reimburses us for certain defense costs and judgments we have paid. We understand the terms under which said reimbursements may be made. There is a sunset provision in these policies. This provision has been explained, and we understand how it may affect payments under the policy. We also understand payments and the deductible of our occupational injury plan will reduce the amount available under a Limited Employers Indemnity policy.

   d. **Occupational Accident Insurance and Occupational Long Term Disability** coverages are employee benefits and do not insure any risk of the Policyholder. These policies are not indemnity coverages and do not protect the Policyholder from loss or damage on account of accidental injury, disease, sickness, or death of an employee. These policies are not liability insurance. No coverage offered by these policies is intended to, nor will it provide us any protection or defense against any suit which may be brought by anyone for any reason. The insurance carrier is not authorized to and does not sell workers' compensation.

   e. **There may be benefits paid under our ERISA Plan or workers' compensation policy that are not reimbursable/payable by these insurance contracts.**

   f. Changes in any ERISA or workers' compensation policy attached to the application for the insurance contract do not change the reimbursement amount or terms of the benefits of the insurance policy issued, unless such changes are consented to in writing by the insurance carrier.

   g. Special Insurance Services, Inc. (SIS) may administer the claims on behalf of the Company. Even when SIS has also been selected as the Third Party Administrator for our ERISA Plan or workers' compensation policy, there may be instances where benefits are payable under our ERISA Plan or workers' compensation policy and are not reimbursable/payable under the insurance contract issued by the Company.

   h. Any plan created by an employer to provide benefits to its employees may be subject to the Employee Retirement Income Security Act of 1974. If so, this may require certain information be filed with the regulatory authorities and communicated to our employees in a certain manner. The Company has informed us that it is an employers obligation to comply with this law.

   i. THIS IS NOT A POLICY OF WORKERS' COMPENSATION. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE CONTRACT, AND IF THE EMPLOYER IS A NONSUBSCRIBER, THE EMPLOYER LOSES CERTAIN COMMON-LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATION ON LIABILITY THAT WOULD BE AVAILABLE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NONSUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

4. In lieu of submitting state Employment Commission reports, we verify that the payroll and census information, including adjustments, We have (and will submit) does (and will) accurately reflect the wage and employment status of our company. We understand the premium charged for the coverage is calculated from the payroll and census information we submit. We further understand that any misrepresentation of this data could result in a reduction or denial of benefits.

Signature	Date	Agent's Signature	Date
Title (must be signed by a corporate officer)		Agency	

Level Premium Installment Option

We hereby apply for the Level Premium Installment Option. We understand this option is only available if approved by the Company and that we will be notified in writing of such approval. We have included our last four quarterly Employment Commission reports for the Underwriter to review as a part of the approval process.

We further understand and agree to the following terms and conditions of the Level Premium Installment Option:

1. The Level Premium is a minimum and deposit premium and is fully earned by the Company;

2. An audit of our records will be conducted to determine the total premium due based on the premium rates stated in the policy;

3. We will pay any additional premium due as a result of the audit within 30 days of the date the Company invoices us for such additional premium;

4. We will pay interest of 1% per month on the amount of premium remaining unpaid 30 days after the date of the invoice for such premium;

5. We will pay any costs the Company incurs in the audit premium if we fail to pay the invoiced amount within 30 days of the date of the invoice. (These include, but are not limited to, collection agency fees, legal fees, and court costs.)

Signature	Date	Agent's Signature	Date
Title (must be signed by a corporate officer)		Agency	

INFORMATION SHEET

Legal Name of Group: _____
As it should appear on the Policy — List subsidiaries / affiliates to be covered on back

Address: _____

Phone #: _____ Federal Tax I.D. #: _____ SIC# _____

Fax #: _____

Contact Name: _____ Nature of Business: _____

Are you required to file with the Railroad Commission: ☐ Yes ☐ No
(If Yes, contact your General Agent for special requirements.)

Are Owners to be Covered? ☐ Yes ☐ No Are they on the State Employment Commission Report ☐ Yes ☐ No

Please print all owners' names: _____

Requested Effective Date: _____

Deductible Requested: ☐ $500 ☐ $1000 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other _____

Benefit Period: ☐ 52 Weeks ☐ 104 Weeks ☐ 156 Weeks

Coverage Selected: ☐ Occupational Only ☐ 24-Hour

Choose One: ☐ Loss of Use (Or) ☐ Permanent and Total Disability

Is Policy to Cover: ☐ Employee Only ☐ Employee and Contract Labor

Classes	# Lives	DEFINITION	CARE BENEFIT	MONTHLY PAYROLL*	MONTHLY FACTOR	MONTHLY PREMIUM
Class A					X =	
Class B					X =	
Class C					X =	
Class D					X =	
Class E					X =	
Class F					X =	

Total Monthly Premium For All Classes: $ _____
(Minimum $50)
Monthly Administration Fee: $ $25.00

Total Monthly Cost: $ _____

(Payable to Fidelity Security Life Insurance Company)

* Maximum monthly payroll should not exceed $5,000 on ANY single employee. If covered, owner must report at least $1,000 a month salary unless a lower salary is shown on the State Employment Commission Report. The Payroll used should be the most recent 30 day period available, e.g. the prior calendar month's payroll.

Agent Name: _____

Phone #: _____ Fax: _____ Agent #: _____

This form does not bind any agent or insurance company to coverage. This is a Quotation / Policy request form and will not effect any insurance until approved by the Company or its representatives. The information above is true and acceptable to the best of my knowledge.

_____ _____ _____
Applicant's Signature (Officer) Title Date

_____
Print / Type Name Above

Census Information Form

CENSUS INFORMATION FOR: _____ AGENT: _____

(Must Be Typed)

Please asterisk all employees age 70 or over DATE: _____

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY	CLASS CODE

PREPARED BY: _____ DATE: _____

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY	CLASS CODE

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY	CLASS CODE

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY	CLASS CODE

AGENT DISCLAIMER

RE: Corporate Accident for Responsible Employers
Fidelity Security Life Insurance Company

Group Name: _____

Requested Effective Date: _____

The Corporate Accident for Responsible Employers plan has been fully explained to me and I understand that this plan covers:

_____24-Hour Accidental Bodily Injury; or
_____Accidental Bodily Injury while on the job only;

and that certain conditions or disabilities that may be work related and compensable according to Workers' Compensation Statutes are not covered, nor are they intended to be covered under this program.

I further understand and agree that this Plan is not in lieu of and does not affect any Statutory requirements under any Workers' Compensation Insurance Laws.

I have explained to the employer the exact provisions and outline of coverages afforded by the Corporate Accident for Responsible Employers plan. I have not represented this product to be a replacement for Workers' Compensation Insurance, nor have I offered any encouragement or recommendation to the employer to discontinue any Workers' Compensation coverage.

I understand that any misrepresentation and resulting litigation expense will be my sole responsibility.

_____ _____
Agent Signature Date

_____ _____
Witnessed Date

SPECIAL INSURANCE SERVICES, INC.
(Hereinafter called the Company)

SINGLE CASE AGREEMENT

This section must be completed by Agent/General Agent

Agent/General Agent	Agent Number	Commission Percent*
_____	_____	_____ **% (New & Renewal)**
_____	_____	_____ **% (New & Renewal)**
_____	_____	_____ **% (New & Renewal)**

*This should be the percent of premium

ACCOUNT NAME: _____

NUMBER OF ELIGIBLE PERSONS: _____

PLEASE READ THE REVERSE SIDE OF THIS FORM AND SIGN BELOW
(No reproductions of this form will be accepted)

AGREED: Special Insurance Services, Inc.

Signed: _____ Dated: _____

AGREED:

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Instructions:
The Writing Agent must complete this Agreement and submit it, along with the new business information, to the General Agent. The General Agent will complete the Agreement and forward it to Special Insurance Services. No Agent will be paid commission until he/she is appointed by the underwriting carrier.

1. The Company agrees to pay you as full remuneration for services rendered for the production of insurance premiums a commission, as listed above, on the premiums paid to the Company and received by the Company, and earned by the Company.

2. The commission provided herein shall not be payable after (a) the date on which you are no longer recognized by the employer as its Agent or Broker for this insurance; (b) the Department of Insurance has issued rules or adopted regulations affecting the commissions herein or necessitating the revision of such insurance. In the event of such contingency, this agreement shall be subject to renegotiation; (c) your ceasing to be a licensed Agent or Broker for any reason; (d) your ceasing to be an appointed Agent of the Company; (e) permanent or temporary loss of license for any reason.

3. The Agent/Broker shall receive compensation as specified for as long as the Company receives compensation at the same level as of the date of the execution of this Agreement, or until commission for all such policies is reduced by the Company. In the event of a reduction in the Company's income from levels applicable on the date of this contract, both parties agree that adjustments will be made accordingly.

4. This contract can be terminated by either party sending not less than 30 days written notice of such termination.

5. PREMIUMS AND ACCOUNTING

5.1 All premiums are to be paid directly to the Company. The Agent has no authority to alter, modify, waive or change any of the terms, rates or conditions of the Company's Master Policy or certificates, to collect renewal premium, to extend time for payment of premium, or to endorse checks payable to the Company.

5.2 The right of the Agent or any other person to receive commissions shall, at all times, be subordinate to the right of the Company to offset or apply commissions against any indebtedness of the Agent to the Company. This right of offset shall include, but not be limited to, application against any liability incurred by the Company to any person by reason of the negligent or unauthorized acts committed by the Agent or any of his sub-agents or brokers. In the event commissions due hereunder are not sufficient to satisfy the debt, the Company may require immediate repayment of the debt from the Agent. An extension of time for repayment or modification of the amount due shall not waive the Company's rights hereunder.

5.3 All accounting and records of the Agent pertaining to Insurance written through the Company shall be subject to inspection and audit by the Company at any reasonable time.

6. GENERAL PROVISIONS

6.1 The Company shall not be responsible for any expenses incurred by the agent whether on the Agent's or Company's behalf. The Company shall administer the program and pay for all application forms, certificates, renewal billings and reporting forms.

6.2 Should the Company, for any reason, refund any premium on any policy or insured enrolled by any application procured by the Agent, his sub-agent or broker, the Agent shall be liable and shall make repayment of any commission paid to the Agent for the policy or application.

6.3 The assignment of commission or any other funds that may be due the Agent under this Agreement is prohibited and shall not be valid unless authorized in advance in writing by the Company. Any such authorized assignment shall at all times be subject to any and all indebtedness of the Agent to the Company.

6.4 All notices, requests, communications and demands under this Agreement shall be in writing and shall be duly given if delivered in person or sent by registered mail, postage prepaid to the party entitled to notice at the address which appears in the records of the Company.

Offered by:

Affiliated Marketing Group
2925 Briarpark, #155
Houston, TX 77042

(713) 977-0611 phone (800) 947-8106 toll-free (713) 977-3877 fax

Underwritten by:

Fidelity Security Life Insurance Company
Kansas City, Missouri

Rated A- Excellent, Based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry.

Arranged through:

SIS

Special Insurance Services, Inc.
6509 Windcrest Drive, Ste. 200
Plano, TX 75024
972-788-0699 Phone
972-960-0377 Fax

This brochure contains a brief description of the plans of insurance offered to qualified employers. The exact provisions governing the insurance are contained in the master policy issued to each group on form number M00223.