

EXCLUSIONS

Benefits will not be paid for:

- 1) a Covered Person's loss which is proximately caused by or results from his own:
 - a. Intentionally self-inflicted Injury, suicide or any attempt thereof Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a Doctor (Accidental ingestion of a poisonous substance is not excluded); b. Commission or attempt to commit a felony; c. Participation in a riot or insurrection.
- 2) A Covered Person's loss which is caused by or results from:
 - a. declared or undeclared war or act of war; b. an act of terrorism; b. an Injury sustained while in the service of the Armed Forces of any country.
- 3) An Injury that is caused by flight in an aircraft, except as a fare-paying passenger.
- 4) Charges which:
 - a. The Covered Person would not have to pay if he did not have insurance; or b. are in excess of usual and customary charges.

CLAIMS

Please forward all claims to A-G Administrators, Inc. P.O. Box 979 Valley Forge, PA. 19482

PAYMENT OF CLAIMS

Benefits will be paid to the claimant, to the designated beneficiary, or to the estate.

ENROLLMENT PROCEDURE

- 1) Complete the attached enrollment form.
- 2) Make your check payable to A-G Administrators, Inc.
- 3) Mail completed enrollment form and check to A-G Administrators, Inc.
- 4) Renewals are the responsibility of the applicant.

COST PER PARTICIPANT AND DEPENDENT(S)

The cost of coverage under this Insurance Plan is \$100.00 per participant for the Insured and \$100.00 per any eligible Dependents.

REFUNDS

All premium received by the Plan Administrator will be considered fully earned and non-refundable.

PRORATION OF COST

There will be no proration of plan costs.

NOTICE

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING THIS COVERAGE, YOU MAY CONTACT UNITED STATES FIRE INSURANCE COMPANY AT 5 CHRISTOPHER WAY EATONTOWN, NEW JERSEY 07724 or CALL (732) 676-9800.

If after contacting Us You are still not satisfied with the resolution to Your problem related to this coverage you may contact the Department of Insurance at the following address: California Department of Insurance, Consumer Communications Bureau 300 South Spring Street, South Tower, Los Angeles, CA 90013 or call them at 1-800-927-HELP (4357) or 213-897-8921 or TDD Number: 1-800-482-4TDD (4833).

REPATRIATION, MEDICAL EVACUATION, & ACCIDENTAL DEATH & DISMEMBERMENT ACCIDENT INSURANCE PLAN FOR FOREIGN SCHOLARS and STUDENTS VISITING THE UNITED STATES WHO ARE SPONSORED BY UNIVERSITY OF CALIFORNIA



**A-G Administrators, Inc.
P.O. Box 979
Valley Forge, PA. 19482**

CA Insurance License: 0B36194

Important Notice

This brochure is a summary of the insurance plan as specified in the Policy (Form GA26932-CA), issued to and on file with the University. This brochure is subject to the terms and conditions of the Policy, which contains all benefits, limitations and exclusions as underwritten by United States Fire Insurance Company. In the event of a discrepancy, the Policy will prevail.

The coverage is for Accidents Only. Benefits described are not payable for loss due to Sickness. The coverage provided pays benefits for specific losses from Accidents only.

United States Fire Insurance Company

Plan Number: US747017 Effective: May 14, 2017

ELIGIBILITY FOR COVERAGE

As described as an Eligible Class on the Application and will include all International students, exchange visitors, visiting faculty members, scholars or other persons with a current passport or Student visa who are temporarily residing outside their Home Country while actively engaged in educational activities or educational research related activities of the Policyholder, and any eligible Dependents.

PERIOD OF INSURANCE

A. Effective Date of Insurance – Provided the required premium is paid, your insurance will become effective on the later of:

- The Plan Effective Date;
- 12:01 a.m. Standard Time on the date you indicated on the Enrollment Form;
- 12:01 a.m. Standard Time on the Effective Date required by the Member School; or 12:01 a.m. Standard Time on the date the Enrollment Form and premium are received by the Plan Administrator.

B. Termination of Insurance – Your Insurance will terminate the earlier of:

- 12:01 a.m. Standard Time on the date for which your premium has been paid;
- 12:01 a.m. Standard Time on the date you cease to be eligible for this insurance;
- 12:01 a.m. Standard Time on the date you depart your Country Assignment for your Home Country; or 12:01 a.m. Standard Time on the date The Plan is terminated.

DEFINITIONS

“**Accident**” means a sudden, unforeseeable external event which causes Injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

“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 Certificate.

“**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 19 years of age;
- (b) 19 but less than 25 years of age and enrolled in a School as a full time student; or
- (c) 19 or more years of age, and primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap.

Child can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

“**Injury**” means bodily harm of which an Accident is the proximate cause. 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.

REPATRIATION BENEFIT -- \$25,000 MAXIMUM BENEFIT

If a Covered Person should die from a covered Accident or Injury, benefits will be paid for the usual and customary expenses incurred for the preparation and transportation of your body to your home country, not to exceed a maximum benefit of \$25,000. All expenses must be approved by The Plan Administrator before the body is prepared for transportation.

ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT BENEFITS

If as a result of a covered Injury, the Covered Person sustains any one of the losses shown below within one year from the date of the covered Accident, benefits will be payable as follows:

Loss of:

Life	\$10,000
Both Hands	\$10,000
Both Feet	\$10,000
Entire Sight of Both Eyes	\$10,000
One Hand and One Foot	\$10,000
One Hand and Entire Sight of One Eye	\$10,000
One Foot and Entire Sight of One Eye	\$10,000
One Hand	\$ 5,000
One Foot	\$ 5,000
Entire Sight of One Eye	\$ 5,000
Thumb and Index Finger of the same hand	\$ 2,500

If the Covered Person sustains more than one Loss as a result of one Covered Accident, benefits will be payable only for the largest amount to which such Person is entitled.

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means 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 between the fingers and the hand. “**Severance**” means the complete separation and dismemberment of the part from the body.

MEDICAL EVACUATION BENEFIT -- \$50,000 MAXIMUM BENEFIT

If an emergency evacuation is required due to a covered Injury, and a Physician determines that adequate medical care cannot be performed locally while the Covered Person is outside of his home country, benefits will be paid for the Usual and Customary expenses incurred, not to exceed the maximum benefit amount of \$50,000. Benefits will be provided for:

- 1) medical services required for evacuation to the nearest adequate medical facility; and
- 2) escort services, if the Covered Person is disabled and on the recommendation of a Physician; and
- 3) ambulance service to the nearest airport and air ambulance upon departure; and
- 4) special air transportation costs to return the Covered Person to his home country, if his Doctor recommends in writing that his condition requires a stretcher, oxygen or other special medical arrangements expenses above the cost of a return airfare ticket held by the Covered Person, or in the absence of a ticket, the cost of an economy airfare ticket.

REPATRIATION, MEDICAL EVACUATION, & ACCIDENTAL DEATH & DISMEMBERMENT ACCIDENT INSURANCE ENROLLMENT FORM

The Policyholder of this Insurance Plan is the University of California

PLEASE PRINT – ANSWER ALL QUESTIONS

Last Name (Surname) _____ First Name (Given Name) _____

USA Street Address _____ City, State, Zip Code _____

Phone #: _____ E-mail Address (if you would like to receive confirmation of insurance) _____

Male ___ Female ___ Date of Birth -- Month: _____ Day: _____ Year: _____

I want my insurance to start on: Month: _____ Day: _____ Year: _____

Passport # _____ Home Country _____

Beneficiary (for Accidental Death Benefit) _____ Relationship to Insured _____

Name of Dependents to be insured:

Spouse _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____

These rates are valid for coverage which has an effective date on or after May 14, 2017. There are no refunds or prorated terms.

Eligible Person and Dependents:

\$100.00 per Student

\$100.00 per Spouse or Dependent

Total Cost Enclosed: _____

Payment provides coverage for up to one year and only while in the United States of America.

Fraud Warning: 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.

Required Disclosure under California Insurance Code § 10270.3: Please note that all benefits payable under this Certificate may be subject to reduction, to the extent provided in this Certificate, to the extent that you are entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance policy or contract, hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.

Applicant Signature: _____ Date: _____ Department: _____ Dept. Phone #: _____

Name of Department Administrative Assistant or International Student/ Scholar Advisor: _____

US747017

Make check or money order payable to A-G Administrators, Inc. and mail to A-G Administrators, Inc. P.O. Box 979 Valley Forge, PA. 19482
U.S. CURRENCY ONLY.