BENEFIT PROVISIONS

ACCIDENT EMERGENCY TREATMENT BENEFIT: If a covered person receives treatment for injuries sustained in a covered accident, we will pay this benefit for treatment received. This benefit is payable for treatment by a physician, treatment received in a hospital emergency room, or X-rays. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per covered person.

ACCIDENT HOSPITAL CONFINEMENT BENEFIT: When a covered person is confined to a hospital for at least 18 hours for treatment of injuries sustained in a covered accident, we will pay this benefit for each day of hospital confinement for which a covered person is charged for a room. We will pay this benefit up to 365 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

INTENSIVE CARE UNIT CONFINEMENT BENEFIT: While a covered person is receiving the Accident Hospital Confinement Benefit, we will pay an additional benefit for each day the covered person is confined and charged for a room in an Intensive Care Unit. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

SPECIFIC-SUM INJURIES: If a covered person receives treatment for injuries sustained in a covered accident, we will pay benefits for the treatments listed:

A. **Dislocation (reduced under general anesthesia):** We will pay for no more than two dislocations per covered accident, per covered person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25% of the benefit amount for the closed reduction dislocation.

B. **Burns:** Must be treated by a physician within 72 hours after a covered accident.

C. **Skin Grafts:** If a covered person receives one or more skin grafts for a covered burn, we will pay a total benefit not to exceed 50% of the burn benefit paid.

D. **Eye Injury:** If a covered person sustains an injury to their eye, we will pay this benefit for a surgical repair of the injured eye or for the removal of a foreign body from the eye by a physician. We will only pay one of these benefits per eye, per covered accident.

E. **Lacerations:** If a covered person sustains a laceration, and is treated by a physician to repair the laceration within 72 hours of the accident, we will pay this benefit.

F. **Fractures:** We will pay this benefit for no more than two fractures per covered accident, per covered person. We will pay 25% of the closed reduction benefit amount for chip fractures and other fractures not reduced by open or closed reduction.

G. **Coma:** If a covered person suffers a coma as a result of a covered accident, and the coma begins within 72 hours of the accident and lasts at least 7 consecutive days, we will pay this benefit. A coma that is medically induced or sustained, as part of your course of treatment, is excluded from coverage.

H. **Paralysis:** If a covered person suffers paralysis as a result of a covered accident, we will pay this benefit for quadriplegia (paralysis of four limbs) or paraplegia (paralysis of the lower limbs). The duration of the paralysis must be a minimum of 30 days. This benefit will be payable only once per covered person.

I. **Surgical Procedures:** Treatment must be performed within 120 days of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be paid based upon the most expensive procedure. We will pay this benefit for open abdominal surgery (including exploratory laparotomy), cranial, hernia, or thoracic surgery. We will pay a benefit for miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum injury benefit (Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.)

MAJOR DIAGNOSTIC EXAMS: If a covered person requires one of the following exams for injuries sustained in a covered accident and a charge is incurred, we will pay this benefit: CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). These exams must be performed in a hospital, a physician's office, or an ambulatory surgical center. This benefit is limited to one payment per calendar year, per covered person.

PHYSICAL THERAPY BENEFIT: If a covered person receives emergency treatment for injuries sustained in a covered accident and later a physician advises the covered person to seek treatment from a physical therapist, we will pay this benefit. Physical therapy must be for injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. We will pay for one treatment per day for up to a maximum of 10 treatments per covered accident, per covered person. The treatment must take place within six months after the accident.

PROSTHESIS BENEFIT: If a covered person requires use of a prosthetic device as a result of injuries sustained in a covered accident, we will pay this benefit. This benefit is not payable for hearing aids, wigs, or any dental aids to include false teeth. This benefit is payable once per covered accident, per covered person.

AMBULANCE BENEFIT: If a covered person requires ambulance transportation to a hospital or emergency center for injuries sustained in a covered accident, we will pay this benefit. Ambulance transportation must be within 72 hours of the covered accident. We will pay this benefit for transportation provided by an air ambulance. A licensed professional ambulance company must provide the ambulance service.

BRIAN A. MARTIN, UTUIA FIELD SUPERVISOR
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824-GEN

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UNITED TRANSPORATION UNION INSURANCE ASSOCIATION

A FRATERNAL BENEFIT SOCIETY

Accident Indemnity

FOR ACCIDENTS ONLY - ON OR OFF THE JOB!

COSTS LESS THAN $1.00 A DAY!

INJURIES OCCUR EVERY...

15 seconds involving a motor-vehicle
10 seconds at work
3 seconds off the job
2 seconds at home

National Safety Council, Injury Facts, 2010 Edition

UTUIA's PROMISES TO YOU

- *All benefits are paid directly to you.*
- *Benefits are always payable at full value regardless of any other insurance you may have.*
- *Only YOU can cancel your coverage.*
- *No physical required.*
- *Benefits will NEVER be reduced.*
- *Your premium does not increase with age.*
- *You will never be singled out for a rate increase.*
- *Guaranteed renewable to age 80.*
- *No payback provisions, including FELA and railroad retirement.*

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ALL THESE BENEFITS FOR LESS THAN $1.00 PER DAY!

ACCIDENTAL INJURY * BENEFITS	PLATINUM PLAN Benefit Level 2		GOLD PLAN Benefit Level 1	
	Insured/Spouse Rider	Children's Rider	Insured/Spouse Rider	Children's Rider
Emergency Treatment	$100	$50	$75	$37.50
Payable for treatment by a physician, treatment received in a hospital emergency room, or for X-rays.				
Hospital Confinement	$300	$150	$225	$112.50
Payable for each day confined to a hospital for at least 18 hours and charged for a room for treatment of injuries sustained in a covered accident.				
ICU Confinement	$400	$200	$300	$150
Payable in addition to the Hospital Confinement Benefit when confined and charged for an Intensive Care Unit room.				
Specified Sum Benefits	$60 to $12,000	$30 to $6,000	$45 to $9,000	$22.50 to $4,500
Benefit paid for specific injuries or procedures (see policy for complete details) such as: Dislocations, Burns, Skin Grafts, Eye Injuries, Lacerations, Fractures, Coma, Paralysis, Surgical Procedures				
Major Diagnostic Exams	$200	$100	$150	$75
Payable for CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram).				
Physical Therapy	$40	$20	$30	$15
Payable for treatment by a physical therapist.				
Prosthesis	$600	$300	$450	$225
Payable if a covered person requires use of a prosthetic device.				
Ambulance	Ground - $200 Air - $1,200	Ground - $100 Air - $600	Ground - $150 Air - $900	Ground - $75 Air - $450
Payable if a covered person requires ambulance transportation to a hospital or emergency center.				

* *Accidental Injury – You will be eligible for benefits under this policy if your injury is caused directly, and independently of all other causes, from accidental injury.*

Platinum and Gold Monthly Premium

Issue Ages	Insured	Spouse Rider
59 and under	$28.00 / $22.00	$23.00 / $18.00
60 - 65	$30.00 / $24.00	$25.00 / $20.00

Insured and Spouse Rider have identical benefits.

Issue Ages	Children's Rider
0 - 18	$21.00 / $16.00

Children's Rider covers ALL children.

Insurance Association
A FRATERNAL BENEFIT SOCIETY

ACCIDENT INDEMNITY APPLICATION
To
United Transportation Union Insurance Association
24950 Country Club Boulevard, Suite 340
North Olmsted, Ohio 44070-5333

PLEASE COMPLETE SECTIONS 1 THROUGH 11 IN FULL. (Print clearly in black ink)

1. Name_____ Soc. Sec _____ Phone _____
   (First / Middle Initial / Last)

   Address _____
   (Street / City / State / ZIP)

2. I am requesting coverage for myself and my family members listed below. I understand that children age 19 or older at the effective date of this policy are not eligible for coverage.

Proposed Insured (List children youngest to oldest)	Sex	Date of Birth (Month/Day/Year)	Age	Proposed Insured (List children youngest to oldest)	Sex	Date of Birth (Month/Day/Year)	Age
Myself:				Child:			
Spouse:				Child:			
Child:				Child:			
Child:				Child:			

3. I have selected: ☐ Benefit Level 2 ☐ Benefit Level 1

4. I want my coverage to become effective on the first day of _____ (month) _____ (year).

5. I have enclosed my first month's premium of $_____, payable to **"UTU Insurance Association"**.

6. I wish to be billed for premiums (check only one): ☐ Annually ☐ Semi-annually ☐ Quarterly
   ☐ Monthly through payroll deduction If payroll deduction, provide _____.
   (Name and Local No. of UTU Member)

7. Beneficiary Designation (person to be paid at death). If no beneficiary named, proceeds will be paid to insured's estate.
   _____ _____ _____ _____
   (First Name / Middle Initial / Last Name / Relationship to Insured)

8. I will own this policy unless I name another person on the line below.
   _____ _____ _____ _____ _____
   (First Name / Middle Initial / Last Name / Relationship to Insured / Social Security No.)
   _____ _____ _____ _____
   (Street / City / State / ZIP)

9. Will this insurance replace or change any existing insurance (including UTUIA Insurance)? ☐ Yes ☐ No
   If yes, provide details: _____ _____
   (Company Name / Policy No.)

10. Do you give UTUIA permission to use your name for marketing purposes? ☐ Yes ☐ No

11. I represent that all statements and answers in this application are true and complete to the best of my knowledge and belief. I agree the insurance shall take effect when the first month's premium is received and accepted by UTUIA, and a policy is issued. The applicant and insurance representative certify that the applicant has read or had read to them the completed application, and realize that any false statement or misrepresentation herein may result in loss of coverage under the policy. If the owner is other than the proposed insured, the proposed insured agrees that the owner alone is entitled to all privileges incident to ownership of this policy. No notice to or consent of the proposed insured is required for any policy transaction between UTUIA and the owner.

_____ _____ _____
UTUIA Representative Signature *Member/Applicant Signature* *Date*

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

OFFICE USE ONLY: LIR CODE ☐☐ FS CODE ☐☐☐☐ OFFICE CODE ☐☐

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