

A STOCK COMPANY



MARKEL INSURANCE COMPANY

Shand Morahan Plaza, Evanston, Illinois 60201

**BLANKET
ACCIDENT AND HEALTH POLICY
SPECIAL RISK**

THE ATTACHED DECLARATIONS PAGE, SPECIAL POLICY CONDITIONS, FORMS,
AND ENDORSEMENTS COMPLETE THIS POLICY.

SECTION 2 DEFINITIONS

You, your or yours means the Policyholder shown in Section 1.

We, us or our means Markel Insurance Company.

Insured Person means a member of the class(es) of person(s) as shown in Section 1, while they are covered under this Policy.

Physician means any practitioner of the healing arts, licensed by the state in which he practices and acting within the scope of his license, including a duly licensed podiatrist, surgeon, osteopath, dentist, chiropractor, optometrist, psychologist, physical therapist and graduate nurse. Physician shall not include a member of the Insured's immediate family.

Hospital means a licensed institution including a tax supported institution of the state which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a Registered Nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full service wing.

Ambulatory Surgical Center or Ambulatory Medical Center means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Loss means medical Expense caused by Injury or Sickness and covered by the Policy.

Injury means bodily harm caused by an accident which occurs while this Policy is in force and is the sole cause of the Loss.

Sickness means disease or illness which; (a) is first diagnosed and treated while the Insured is covered under this Policy; and (b) causes a Loss to the Insured which is covered by this Policy. "Sickness" includes Normal Pregnancy and Complications of Pregnancy.

Pre-existing Condition means the existence of symptoms which would cause a person to seek diagnosis, care or treatment within a one-year period preceding the effective date of the coverage of the Insured Person, or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a one-year period preceding the effective date of coverage of the Insured Person.

Complications of Pregnancy means conditions whose diagnoses are distinct from pregnancy, but are adversely affected by or are caused by pregnancy. Such complications include, but are not limited to: a) acute nephritis; b) nephrosis; c) cardiac decompensation; d) missed abortion; e) hyperemesis gravidarum; f) preeclampsia; and g) similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes: a) nonelective Cesarean section; b) ectopic pregnancy which is terminated; and c) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy shall not mean: a) false labor; b) occasional spotting; c) Physician prescribed rest during the period of pregnancy; d) morning sickness; or e) similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct Complication of Pregnancy.

Prescription Medicines or Drugs means any medicine or drug, under applicable state law, that is dispensed only with a written prescription from a Physician and has a label bearing the legend: "Caution: Federal law prohibits the dispensing without a prescription." It is also any mixed medicine with at least one ingredient bearing the above legend.

Expense means the Usual and Customary charges for Medically Necessary treatment, service or supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

Usual and Customary Expense means an Expense which (a) is charged for treatment, supplies or medical services Medically Necessary to treat

the Insured's condition; and (b) does not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where the Expense is incurred.

Medically Necessary means medical services, supplies or treatment authorized by a Physician to treat an Insured Person's bodily Injury which are: (a) consistent with the symptoms or diagnosis; (b) appropriate and accepted according to good medical practice standards; (c) not primarily for the convenience of the Insured Person, Physician or other providers; and (d) consistent with the most appropriate supply or level of services which can safely be provided to the patient.

The Aggregate Limit of Indemnity stated in Section 1 shall be the total limit of our liability for all coverages payable under the Policy with respect to all classes of Insured Persons arising out of Injury sustained by two or more Insured Persons as the result of any one accident. If the total of such indemnities exceed the Aggregate Limit of Indemnity, we shall not be liable to any one Insured Person for a greater proportion of such Insured Person's indemnity than said Aggregate Limit of Indemnity bears to the total indemnities afforded by the coverage to all such Insured Persons.

Deductible means the amount an Insured is required to pay as provided by the applicable coverage under this Policy in the event of a Loss.

Home Health Care Expenses means the care and treatment of an Insured who is under the care of a Physician, only if hospitalization or confinement in a skilled nursing facility as defined in title XVIII of the Social Security Act would otherwise have been required if home care was not provided, and the plan covering the Home Health Service is established and approved in writing by such Physician. Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to public health law.

SECTION 3 EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION AND RENEWAL

This Policy is effective on the Effective Date in Section 1 and expires on the Expiration Date. With our consent, it may be renewed by paying the renewal premium within the grace period in Section 5. Upon 60 days' prior written notice, we may change the premium rate, but not more often than once every twelve months. We reserve the right to refuse to renew the Policy.

SECTION 4 EFFECTIVE DATE OF INDIVIDUAL INSURANCE

The persons eligible for inclusion as Insured Persons shall be all persons denoted in classifications described in Section 1. Insurance for such eligible persons shall become effective with respect to the activity and/or trip covered and benefits designated in Section 1 on the effective date in Section 1.

The insurance for any Insured shall terminate on the earliest of the following dates:

1. The date the Policy expires;
2. The premium due date if you fail to pay the required premium for the Insured, subject to the Grace Period, except as the result of inadvertent error; or
3. The date the Insured ceases to be a member of any class, as shown in Section 1.

Termination of coverage will not affect any claim which starts before termination.

SECTION 5**POLICY PROVISIONS****Change of Beneficiary**

The Insured can change the beneficiary at any time giving us written notice. The beneficiary's consent is not required for this or any other change in the coverage.

Conformity With State Statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which it is issued or in which the Insured Person resides, is hereby amended to conform to the minimum requirements of such statutes.

Assignment

This policy and an Insured's coverage may not be assigned.

Records Maintained

You must maintain adequate records of this insurance.

Examination and Audit

At any reasonable time and for any purpose relating to this Policy, your records shall be open for our inspection and audit. Such examination may be made during the Policy term; within 3 years after the Policy is terminated; or until final settlement of all claims hereunder, whichever is later.

Subrogation

When benefits are paid to or for an Insured Person under the terms of this Policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured Person once the Insured has been indemnified for his Loss, against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury or Sickness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by us of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

Right of Recovery

Payments made by us which exceed the Covered Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder, shall be recoverable by us from or among any persons, firms, or corporations to or for whom such payments were made.

Workers' Compensation

This Policy is not in place of and does not affect any requirement for such coverage by workers' compensation insurance.

SECTION 6**COVERAGE**

All Policy benefits are as indicated in Section 1 - Schedule of Insurance and as described herein, or in riders attached to and made a part of this Policy.

Accident Medical Expense Benefit

When an insured's Injury requires:

- (a) treatment by a Physician;
- (b) Hospital services;
- (c) services of a licensed practical nurse or RN;
- (d) x-ray service;
- (e) use of operating room, anesthesia (including the administration thereof), laboratory service;
- (f) use of an ambulance;
- (g) use of an Ambulatory Surgical Center or Ambulatory Medical Center;
- (h) if ordered by a Physician, prescription medicines, drugs, or any other therapeutic services or supplies; or
- (i) Home Health Care Expenses,

Entire Contract; Changes

This Policy and endorsements signed by the Policyholder and Insurer are the entire contract. Any change, modification or waiver of this Policy or a certificate issued under it must be in writing and signed by one of the following: our President; our Vice-President; a Secretary; or Assistant Secretary.

Grace Period

This Policy has a 31 day Grace Period. If the premium is not paid by the due date, it may be paid during the 31 days immediately following the due date. The Policy will remain in force during the Grace Period. The Grace Period does not apply:

- (a) to the first premium due; or
- (b) to premiums due thereafter if we have given you 60 days prior notice that we will not renew the Policy.

Notice of Claim

Notice of Claim must be given to us within 30 days after a Loss occurs, or as soon thereafter as possible. The notice can be given to us at P.O. Box 2039, Glen Allen, VA 23058-2039. Notice should include the Insured Person's name and Policy Number.

Claim Forms

When we receive the Notice of Claim, we will send the Insured Proof of Loss forms. If we do not send these forms within 15 days, the Insured can meet the Proof of Loss requirement by giving us a written statement of the nature and extent of Loss within the time limit in the Proofs of Loss Section.

Proofs of Loss

Written Proof of Loss must be given to us within 90 days after such Loss. We will not deny or reduce any claim because proof is not filed within this time, if it is filed as soon as reasonably possible. In any event, the proof required must be given, unless the claimant is legally incapacitated.

Time of Payment of Claims

After receiving written Proof of Loss, we will immediately pay all benefits as they accrue.

Payment of Claims

After receiving written Proof of Loss, we will pay all benefits to the Insured, if living, or at the Insured's request, to the Hospital or person rendering services. It is not required that the service be rendered by a particular Hospital or person.

Benefits for accidental death, if any, will be paid to the named beneficiary, other than the policyholder or an officer thereof, if then living. If no beneficiary is named, or the named beneficiary predeceases the Insured, such benefits will be paid to the Insured's estate.

Discontinuance of this Policy will not prejudice any claim incurred while this Policy is in force.

Physical Examination

We, at our expense, have the right to have any Insured examined by a Physician of our choice as often as reasonably necessary, while a claim is pending.

Legal Actions

No legal action may be brought to recover on this Policy: (a) within 60 days after written Proof of Loss has been given as required; or (b) after 6 years from the time written Proof of Loss is required, or after the expiration of the applicable statute of limitations, if greater.

we will pay the Expense, subject to the Coinsurance Percentage, incurred within the Benefit Period after the date of the accident that exceeds the Deductible Amount. Our payment will not exceed the Aggregate Maximum for a single accident.

The Deductible Amount, Coinsurance Percentage, Benefit Period and the Aggregate Maximum are shown in Section 1 - Schedule of Insurance. These amounts apply to each insured.

Accidental Death and Dismemberment Benefits

Accidental Death and Dismemberment Insurance covers the Insured for a Loss as shown below. The Loss must result from an accident, directly and independently of all other causes. The accident must take place while the person is an Insured under this Policy. Also, the LOSS must take place within 52 weeks after the accident.

The following table shows the amounts we will pay:

For Loss Of	Amount
Life	Principal
Both hands or both feet or sight of both eyes	Principal
One hand and one foot	Principal
One hand and sight of one eye	Principal
One foot and sight of one eye	Principal
One hand or one foot or sight of one eye	1/2 the Principal

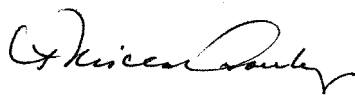
The most we will pay for all Losses to an Insured as the result of one accident is the Principal shown on the Schedule.

Loss to hands and feet means severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of sight.

Accidental Death and Dismemberment Benefits Limitations

We will not pay for a Loss caused in any way by:

1. bodily or mental infirmity or illness;
2. infection; except pyogenic or bacterial infection in a cut or wound caused by an accident;
3. medical or surgical treatment; except for surgery which results from an accident;
4. air travel, other than as a fare-paying passenger on a scheduled commercial flight;
5. war or act of war;
6. taking part in a riot or felony; this shall not include being a victim of a felony;
7. suicide; attempted suicide or intentional self-inflicted injury.



President



Secretary

SECTION 7 EXCLUSIONS

The Policy does not cover Loss nor provide benefits for:

1. Expenses for treatment on or to the teeth, except for treatment resulting from Injury to natural teeth;
2. Services normally provided without charge by you or your employees;
3. Eyeglasses, hearing aids, and examination for the prescription or fitting thereof;
4. Suicide, attempted suicide or intentionally self-inflicted Injury;
5. Injury due to participation in a riot;
6. Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery made medically necessary due to a covered accident or Sickness which results in trauma, infection or other diseases of the involved part;
7. Loss resulting from air travel, except as a fare-paying passenger on a commercial airline;
8. Injury or Sickness resulting from any declared or undeclared war;
9. Injury or Sickness while in the armed forces of any country. When an Insured enters such armed forces, we will refund the unearned pro rata premium to the Insured;
10. Injury or Sickness covered by any workers' compensation or occupational disease law;
11. Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
12. Infections except pyogenic or bacterial infections caused wholly by a covered Injury or Sickness;
13. Hernia, unless it results from a covered Injury;
14. The Insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;
15. Claims occurring while parachuting or hang-gliding; or Injury sustained while traveling in or on any two or three-wheeled motor vehicle operated by a person who does not hold a valid operator's license;
16. Pre-existing Conditions as defined in Section 2, Definitions.

Service Address:
 Markel Insurance Company
 P O. Box 3870
 Glen Allen, VA 23058-3870
 (800) 431-1270

Markel Insurance Company

Policy Number **4102AH021741 - 1**

Evanston, Illinois 60201

(A Stock Insurance Company, Herein Called the Company)

AGREES with the Policyholder, named below in consideration of the payment of the premium and subject to the limits of liability, exclusions, conditions and other terms of the policy:

TO PAY the benefits described in Item 4, Coverage.

SECTION I

SCHEDULE

1. Name of Policyholder: Rose City Soccer Challenge
 Address: 220 Covington Avenue, #45
 Thomasville, GA 31792

2. Policy Period: From 10-01-2011 to 10-03-2011 at 12:01 A.M. Standard Time at your mailing address shown above.

3. Class of Insured Persons:
 All registered participants and volunteers for whom premium has been paid.

Description of Hazards Covered:

Insured persons are covered for Injury resulting from an Accident which occurs directly from: 1) activities that are scheduled, sponsored or supervised by the policyholder; 2) premises owned, leased or borrowed by the policyholder; or 3) travel scheduled, sponsored or supervised by the policyholder.

4. Coverage:

THE POLICY CONSISTS OF THE FOLLOWING COVERAGE PARTS AND RIDERS. THE BENEFIT AMOUNT SHOWN IS THE LIMIT SELECTED BY THE POLICYHOLDER. IF THE COVERAGE WAS NOT REQUESTED BY THE POLICYHOLDER, THAT IS INDICATED BY THE WORD NIL. THE PREMIUM FOR EACH COVERAGE IS ALSO SHOWN AS IS THE TOTAL PREMIUM AT THE BOTTOM OF THE SCHEDULE.

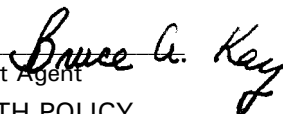
COVERAGE	BENEFIT AMOUNT	PREMIUM
AGGREGATE LIMIT OF INDEMNITY	\$1,000,000	INCL.
ACCIDENT MEDICAL EXPENSE BENEFIT		INCL.
DEDUCTIBLE AMOUNT	\$500	
COINSURANCE PERCENTAGE	100%	
BENEFIT PERIOD	52 Weeks	
AGGREGATE MAXIMUM	\$100,000	
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS		INCL.
PRINCIPAL SUM	\$5,000	
SICKNESS MEDICAL EXPENSE BENEFIT		N/A
DEDUCTIBLE AMOUNT	NIL	
COINSURANCE PERCENTAGE	NIL	
BENEFIT PERIOD	NIL	
AGGREGATE MAXIMUM	NIL	
CATASTROPHIC INJURY BENEFIT		N/A
BENEFIT MAXIMUM	NIL	
MONTHLY INSTALLMENT	NIL	
TOTAL TEMPORARY DISABILITY BENEFIT		N/A
BENEFITS COMMENCE WITH THE	NIL	DAY
RATE PER WEEK	NIL	
PERCENT OF BASIC EARNINGS	NIL	
MAXIMUM PERIOD	NIL	WEEKS
TOTAL:		\$350

5. Form(s) and endorsement(s) made a part of the policy at the time of issue:

M-SR100(01/95), MSR101(01/95), MSR128(01/95), MSR128(01/04), MSR128-AS(03/07), MSR128-BP(08/00), MSR200(01/95), MSR128-AD(03/96)

Countersigned by Bruce A. Kay

Licensed Resident Agent



Insured



Markel Insurance Company

NOTICE OF MARKEL INSURANCE AND MARKEL AMERICAN INSURANCE COMPANY'S PRIVACY POLICY

08-08-2011

While information is the cornerstone of our ability to provide superior service to you, our most important asset is our customer's trust. Keeping customer information secure is a top priority for all of us at Markel. We intend to use information collected only in the normal course of our business and as permitted by law. Following is our privacy policy to our individual customers.

We collect nonpublic personal information about you from the following sources:

- * Information we receive from you on applications or other forms
- * Information about your transactions with us, our affiliates or others, and
- * Information we receive from a consumer reporting agency.

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

We may disclose nonpublic personal information about you to third party financial service providers, such as your insurance agent and/or broker. We may also disclose nonpublic personal information about you to non-affiliated third parties as permitted by law.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with applicable standards to guard your nonpublic personal information.

For further information, please contact us at 1-800-431-1270.

IMPORTANT PRIVACY NOTICE - PLEASE READ

Markel is committed to safeguarding your privacy. We understand your concerns regarding the privacy of your nonpublic personal financial information, and want to assure you that we do not sell this information to anyone for marketing or other purposes. We only use and share this type of information with non-affiliated third parties for purposes of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosures to insurance regulatory authorities or in response to legal process.

Federal law and the various state insurance departments regulate what types of disclosures are acceptable. For example, we are permitted to disclose nonpublic personal financial information as necessary to administer your policy or claim. Representative types of non-affiliated third parties that may be involved in your insurance transaction include the following individuals or organizations:

- * Your insurance agent, broker or agency.
- * A government agency or other organization pursuant to an examination of our records and/or practices.
- * Your attorney, trustee or anyone else who has a legal interest in your policy.
- * Persons to whom a court requires us, by order or subpoena, to provide information.
- * Claims adjusters or investigators.
- * An insurance support organization to prevent or prosecute fraud.
- * Insurance rate advising organizations.
- * Reinsurers.

We have and maintain strict policies and procedures to protect the confidentiality of your nonpublic personal financial information. We maintain physical, electronic and procedural safeguards to protect this information from unauthorized access. Access to your information is restricted to those individuals having a business need for such information.

At Markel, we take your privacy very seriously. Enclosed you will find our privacy notice with your policy.

COMPLETE AND RETURN THIS FORM TO:

Medical/Dental Accident CLAIM FORM



P.O. Box 390 Short Hills, NJ 07078

52-week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

- 1. NAME:(first) (last)
2. ADDRESS: (city) (state) (zip code)
3. TELEPHONE #:
4. BIRTHDATE: / / SEX: Male Female SS#:
5. CLAIMANT IS A: Player Coach Official Other
6. ACCIDENT DATE: / / ACCIDENT TIME: am pm
7. BODY PART INJURED:
8. ACCIDENT OCCURRED DURING: Game Practice Tournament Camp/Clinic Other
9. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:
10. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURED:

SECTION II STATISTICAL INFORMATION (required)

- 1.NAME OF TEAM/CLUB:
2. TYPE: Competitive Recreational
3. LOCATION: On Field Indoor Spectator Area Other
4. SURFACE: Dirt Grass Outdoor Turf Indoor Turf
5. SURFACE CONDITION: Dry/Normal Wet/Rainy Icy Muddy
6. POSITION:
7. STATUS: HIT BY OBJECT COLLISION W/OPPONENT COLLISION W/TEAMMATE OTHER

SECTION III TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

Table with 4 columns: Policy Effective Date, Policy Expiration Date, Policy #, Name of Policyholder. Includes address and telephone number.

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT. YES-SPONSORED/SANCTIONED ACTIVITY YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. AUTHORIZED SIGNATURE: TITLE: DATE:

SECTION IV**STATEMENT OF OTHER INSURANCE****(required)****Claimant/Father**

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Employer: _____

Phone: _____

Self Employed Unemployed

Email: _____

Claimant/Mother

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Employer: _____

Phone: _____

Self Employed Unemployed

Email: _____

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.**IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY?** YES NO**IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID?** YES NO**INSURED NAME:** _____ **ID#:** _____ **INSURED GRP#/NAME:** _____**INSURANCE COMPANY NAME:** _____**ADDRESS:** _____**CITY:** _____ **STATE:** _____ **ZIP:** _____**PHONE:** _____****Please include copy of insurance card (both sides)****Note:** IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____**SECTION V****ASSIGNMENT OF BENEFITS****(required)**

For services rendered or to be rendered I hereby authorize the Insurance Company or their representatives to pay benefits in connection with this accident or injury directly to the doctor, hospital or other provider of service. If paid receipts are submitted with this claim form, benefits will be paid to the insured.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required): _____ **DATE:** _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger or HSR or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): _____ **DATE:** _____

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines**. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.

For claims to be eligible for coverage, you must seek medical attention within **60 days** from date of injury.

Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**

- a) Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
- b) **Itemized bills are required:** You or your providers must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

- **HCFA-1500** is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.

- **UB-04 or UB-92** is the standard form used by Hospitals to show medical treatments and charges made for services.

- Primary Insurance **Explanation of Benefits (if applicable)**.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

- a.) Employer contribution to flex account - Send to Primary insurance first, then flex account, then Bollinger
- b.) Employee contribution to flex account - Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

For further Claims information contact: Bollinger Sports Claims Department

PO Box 390

Short Hills, NJ 07078-0390

Phone: 1-866-267-0093

Fax: 973-921-2876

Email: SportsClaims@BollingerInsurance.com



FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any 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.

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.

ARKANSAS: 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.

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.

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

DISTRICT OF COLUMBIA RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: 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.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: 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.

LOUISIANA: 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.

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

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

MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

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.

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: WARNING: 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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

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 the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: 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.

WEST VIRGINIA: 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.

Markel Insurance Company

Evanston, Illinois 60201

Endorsement No. C


When charges incurred by a claimant are covered under a Health Maintenance Organization (HMO) plan or a Preferred Provider Organization (PPO) plan, and are denied due to the claimant's failure to precertify, this plan will not pay medical benefits.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 10-01-2011 Attached to and forming part of Policy No. 4102AH021741 - 1

of Markel Insurance Company

issued to Rose City Soccer Challenge



President



Secretary

Markel Insurance Company

Endorsement No. 1

For the premium charged and paid it is agreed that:

MSR100, SECTION 2, DEFINITIONS:

ADD: Accident means a sudden, unexpected and unintended event which is identifiable and caused solely by an external physical force resulting in Injury to an Insured person. Accident does not include a Loss due to or contributed to by disease or Sickness.


This rider is attached to and becomes a part of this Policy.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 10-01-2011 Attached to and forming part of Policy No. 4102AH021741 - 1

of Markel Insurance Company

issued to Rose City Soccer Challenge



President



Secretary

Markel Insurance Company

Endorsement No. 1

Markel Insurance Company's address is hereby changed to:

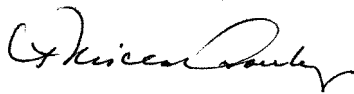
Markel Insurance Company
Ten Parkway North
Deerfield, Illinois 60015

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 10-01-2011 Attached to and forming part of Policy No. 4102AH021741 - 1

of Markel Insurance Company

issued to Rose City Soccer Challenge



President



Secretary

Markel Insurance Company

Endorsement No. 1

In consideration of premium charged, it is understood and agreed that the policy is amended as follows:

Expenses incurred for physical therapy and chiropractic care are limited to \$50 per visit with a per Injury maximum of \$2,000.

Expenses incurred for durable medical equipment is limited to \$1,000 per Injury.

Coverage for Outpatient prescriptions is limited to \$1,000 per Injury.

Medical treatment for a covered Injury must commence within 60 days of the date of Injury.

The Proof of Loss provision is deleted in its entirety and replaced with the following:

"Written proof of loss must be given to Us within 90 days after such Loss. We will not deny or reduce any claim because proof is not filed within this time, if it is not reasonably possible to provide proof. However, such proof must be furnished within one year of the date of loss."

MSR101, Section 1, Item 3, Description of Hazards Covered is deleted and replaced with the following:

3) direct travel to and from covered activities for member officials and referees. Travel coverage for all other members is limited to direct travel as a group to and from covered activities. Group travel is defined as travel organized by the member team or league directly to covered activities.

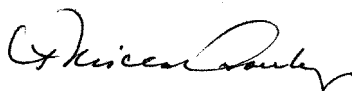
All other terms and conditions of the policy remain the same.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 10-01-2011 Attached to and forming part of Policy No. 4102AH021741 - 1

of Markel Insurance Company

issued to Rose City Soccer Challenge



President



Secretary

Markel Insurance Company

Endorsement No. 1

It is hereby understood and agreed:

SECTION 2, DEFINITIONS:

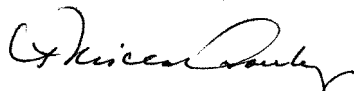
"Benefit Period" means the time during which an Insured Person's incurred expense for a covered injury or sickness is eligible for reimbursement. The "Benefit Period" selected starts on the date of the accident for an injury or the date of the first treatment for a sickness.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 10-01-2011 Attached to and forming part of Policy No. 4102AH021741 - 1

of Markel Insurance Company

issued to Rose City Soccer Challenge



President



Secretary

Markel Insurance Company

Evanston, Illinois 60201

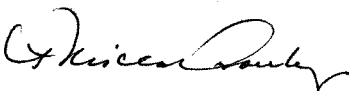
COORDINATION OF BENEFITS FOR ACCIDENT MEDICAL EXPENSE BENEFITS

Such insurance as is afforded by this policy for Accident Medical, are payable only in excess of any expenses payable by other valid and collectible insurance. In the absence of other valid and collectible insurance, it is our intention that expenses incurred in connection with any covered injury shall be fully payable subject to the terms, conditions and limitations of the Policy.

"Other valid and collectible insurance" shall mean any plan providing medical expense benefits for or by reason of dental, physician, nurse, hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by (1) any type of service plan contracts, any group or blanket insurance, employee benefit plan or any plan arranged through an employer, trustee, union or employee benefit association, or (2) any plan or program created or administered by national or state government, or agencies thereof, (3) individual insurance. We will not limit or exclude payment on a claim because the Insured is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act.

This provision shall apply in determining the benefits as to a person covered under this plan for any claim determination period. If an Expense exceeds the amount of benefit payable under any other valid and collectible insurance for such person during such time period, the Company will pay such excess Expenses incurred due to a covered injury.

This rider is attached to and becomes a part of the Policy.



President



Secretary

Markel Insurance Company

NOTICE TO POLICYHOLDERS

The policy to which this notice is attached is subject to a minimum, fully earned premium of \$350.

Should you have any questions regarding this, such questions should be directed to us (the Company) or to your agent.