



ACCIDENT & GENERAL INSURANCE COMPANY, LIMITED

Corporate Office: c/o Artex Risk Solutions (Cayman) Ltd., P.O. Box 10233, 171 Elgin Avenue
Willow House, Cricket Square, George Town KY1-1002 Grand Cayman
(herein referred to as the Company)

DIVER'S CERTIFICATE OF INSURANCE

This plan is underwritten by Accident & General Insurance Company, Limited. (the "Company"). The Company will pay the benefits under the Policy in accordance with and subject to this Diver's Certificate of Insurance. This Certificate is a legal contract between the Company, Policyholder and the Insured. Insureds are covered against losses subject to the provisions, limitations and exclusions contained herein.

Policy Number: G-2025-LOCAL DIVE ACCIDENT (the "Policy")

Policyholder: DAN WORLD, LTD. ("DAN")

Policyholder Address: P.O. Box 10233, 171 Elgin Avenue
The Pavilion Building, Cricket Square
George Town, Grand Cayman KY1 -1002
Cayman Islands

POLICY DECLARATIONS

Coverage is provided as described in the Benefit Schedule. Benefits payable for expenses incurred for all benefits shall not exceed the Benefit Limit or Sublimit shown for that benefit in the Benefit Schedule.

Benefit Schedule	
DAN World - Local Dive Accident Plan	
DAN TravelAssist Benefits	
	Benefit Limit
Emergency Medical Transportation	up to US\$10,000
Repatriation of Mortal Remains	Included
Repatriation for Additional Care	Included
Local Burial	Included
Dive Accident Benefits	
	Benefit Limit
Dive Accident Medical Expenses	up to US\$50,000 LT
	LT - Lifetime

COVERAGE TERRITORY

Coverage under this plan is provided **ONLY WITHIN THE COUNTRY WHERE THIS CERTIFICATE IS ISSUED.** This is local coverage only. Certificates may only be issued in countries approved by the Policyholder. The following countries are not eligible for approval by the Policyholder and no coverage is provided for losses that occur in Afghanistan, Algeria, Chad, Iran, Iraq, Libya, Mali, North Korea, Niger, Nigeria, Somalia, South Sudan, Sudan, Syria, Pakistan, and Yemen. The list of excluded countries may be updated at any time by the Company.

NOTIFICATION AND PRE-AUTHORIZATION

You, or someone acting on your behalf, must contact the Policyholder (DAN) to obtain pre-authorization to use any of the benefits and coverages available under this Policy. The Policyholder maintains a 24/7 hotline to confirm your coverage and provide necessary pre-authorizations. If your situation is life-threatening, seek immediate medical attention. Once your situation has stabilized, you can contact the Policyholder (DAN) with the relevant details for any necessary approvals. If you fail to timely notify the Policyholder (DAN), the benefits available to you may be reduced or denied.

DAN *TravelAssist* benefits (including medevac and other emergency travel assistance services) are only available if all arrangements are made by and coordinated through DAN *TravelAssist*. If services are arranged by the Insured Person (a "self-evacuation") or a third party, the benefits available to you may be reduced or denied.

ELIGIBILITY

Individuals who either: (a) hold a diver certification issued by a recognized training agency, or (b) are in the process of obtaining his/her diver certification and are under the supervision of and diving with a qualified diving instructor affiliated with a recognized training agency. Diving includes all forms of recreational and non-commercial diving such as snorkeling, skin diving, free diving, and SCUBA (Self-Contained Underwater Breathing Apparatus) diving. The individual must be:

1. A resident or citizen of an eligible state, province, country, territory, district, or protectorate; and,
2. Between 8 years of age and 75 years of age. The Policyholder may, in its sole discretion, grant a written exemption to the age limit for individuals over 75. In such cases the person may be asked to provide a medical clearance from a physician trained in diving medicine and acceptable to the Policyholder, which clears the individual for diving activities. (the Policyholder will advise if this is required at time of enrollment).

Coverage Period: One year.

Individual Effective Date: Coverage will take effect on the date a person becomes eligible and pays the requisite premium.

Individual Termination Date: Coverage automatically ends on the first of the following dates:

1. the end of the period for which the last premium has been paid; or,
2. the premium due date coinciding with or next following the date the Insured Person attains age 75, unless the Policyholder has granted the Insured Person a written exemption which allows them to be an Insured Person after age 75.

Termination of coverage will not affect a pending claim for a covered loss.

DEFINITIONS

ACCIDENT means a sudden, unforeseen, and unexpected event that occurs without any intentional act or action by the Insured Person that causes or contributes to the sudden, unforeseen, or unexpected event.

ARTERIAL GAS EMBOLISM (AGE) means signs and symptoms due to gas entering the arterial system as a result of over pressurization of gas-containing body structures during a Covered Dive.

BENEFIT LIMIT or SUBLIMIT means, as applicable to each benefit provided by the Policy, the amount shown as the benefit limit for that benefit for the Insured Person in the Benefit Schedule or herein.

BENEFIT SCHEDULE means the Benefit Schedule section of the Policy Declarations.

CERTIFICATE OR CERTIFICATE OF INSURANCE means this Divers Certificate of Insurance.

COMMERCIAL DIVER means a diver who has obtained a commercial diver certification, who uses scuba or a surface supplied air source, who engages in diving activities as a business venture, and receives compensation or some other form of consideration in exchange for the services rendered. Diving activities of Commercial Divers include, but are not limited to, construction, inspection, search and rescue, salvage, repair, gathering or fishing for seafood, and commercial film production. Commercial Diver does not include dive professionals, independent underwater photographers and videographers, underwater videographers working as part of a small documentary or scientific film crews (subject to approval), scientific divers, and those conducting research or providing services on a volunteer basis.

COMPANY means, Accident & General Insurance Company, Ltd. For administrative purposes, the term "Company" may include its authorized administrator acting on its behalf.

COMPLICATIONS OF PREGNANCY means conditions whose diagnoses are distinct from but adversely affected or caused by pregnancy. These conditions are:

1. acute nephritis or nephrosis; or
2. cardiac decompensation or missed abortion; or
3. non-elective cesarean section; or
4. similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Physician prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

COVERAGE means the Insurance that the Insured Person has under the Policy.

COVERAGE PERIOD means one year from the date the Insured Person's insurance takes effect unless the Coverage ends sooner per the terms of the Certificate.

COVERED DIVE or COVERED DIVING ACTIVITY means:

1. recreational free diving (Apnea), snorkelling, SCUBA diving, or training for free diving or SCUBA certification; or,

2. diving while a SCUBA or free diving instructor, divemaster, or independent recreational underwater photographer/videographer; or,
3. diving as a volunteer in support of marine conservation or marine habitat restoration projects; or,
4. diving while performing research for a state or national government agency or university and following the diving safety guidelines of the American Academy of Underwater Scientists (AAUS), Canadian Academy of Underwater Scientists (CAUS), or other recognized scientific body whose written diving research protocol is approved by the Policyholder.

A Covered Dive begins upon entry into the water and ends upon exit from the water. To be a Covered Dive, the dive must begin while Coverage is in force.

COVERED DIVING ACCIDENT means an Accident or DCI that results from a Covered Dive.

CUSTODIAL CARE means care:

1. provided primarily for the maintenance of the Insured Person; and
2. essentially designed to assist the Insured Person in the activities of daily living.

Custodial Care does not include care primarily provided for its therapeutic value in the treatment of Injury.

DECOMPRESSION ILLNESS (DCI) means Decompression Sickness (DCS) or Arterial Gas Embolism (AGE). Such illness must be a direct result of a Covered Dive that takes place while Coverage is in force.

DECOMPRESSION SICKNESS (DCS) means signs and symptoms resulting from gas in the tissues coming out of solution into bubbles inside the body on depressurization as a result of a Covered Dive.

ELECTIVE TREATMENT AND PROCEDURES means any medical treatment or surgical procedure that is not Medically Necessary including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

FINANCIAL INSOLVENCY means the total cessation or complete suspension of operations due to insolvency, with or without the filing of a bankruptcy petition, or the total cessation or complete suspension of operations following the filing of a bankruptcy petition, whether voluntary or involuntary, by a tour operator, cruise line, liveaboard, airline, rental car company, hotel, condominium, railroad, motor coach company, or other supplier of travel services which is duly licensed in the state(s) of operation other than the person, organization, agency or firm from whom the Insured Person directly purchased or paid for his or her trip. There is no Coverage for the total cessation or complete suspension of operations for losses caused by fraud or negligent misrepresentation by the supplier of travel services.

HOME means the place where the Insured Person lives and maintains their primary residence, irrespective of other residences they may use from time to time. Home is the place designated by the Insured Person as their address on the application form.

HOME COUNTRY means the country or territory where the Insured maintains their Home.

HOSPITAL means an institution, which meets all of the following requirements:

1. it must be operated according to the law;

2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. registered nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not: a rest, convalescent, extended care, rehabilitation, or other nursing facility; a facility which primarily treats mental illness, alcoholism, or drug addiction (or any ward, wing or other section of the Hospital used for such purposes); or a facility which provides hospice care (or wing, ward or other section of a Hospital used for such purposes).

HYPERBARIC CHAMBER means a pressure vessel approved for recompression of diving accident victims and/or use of hyperbaric oxygen therapy, specifically for use for recompression of AGE or DCS.

IMMEDIATE FAMILY MEMBER is the Insured Person or his or her spouse, the children, brothers, sisters and parents or stepparents of either the Insured Person or the Insured Person's spouse, and spouses of the children, brothers, and sisters of either the Insured Person or Insured Person's spouse.

INJURY means bodily harm or damage (not including mental or emotional harm/damages) due to a covered Accident that is not contributed to by disease, sickness, infection, bodily infirmity, or any other abnormal physical condition and that: (i) requires examination and treatment by a Physician; and (ii) occurs while the injured person's Coverage under the Policy is in force. All injuries sustained by one person in any one Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

INPATIENT means the Insured Person who is confined as a registered bed-patient in a Hospital for whom a room and board charge is made.

INSURANCE means the Coverage that the Insured Person has under the Policy.

INSURED or INSURED PERSON means an Eligible Person as defined in the eligibility section of this Policy: 1) who completes any required enrollment form; 2) who pays any required premium or for whom premium has been paid; and 3) while covered under the Policy.

INTENSIVE CARE UNIT means a separate part of a Hospital that is reserved for critically and seriously ill patients who require highly skilled nursing care and constant or close and frequent audiovisual nursing observation. The Intensive Care Unit must provide its patients with:

1. room and board;
2. nursing care by Nurses who work only in the unit; and
3. special equipment and supplies that are primarily for use within the unit.

MEDICAL EMERGENCY means an Injury or emergency Sickness that poses an immediate risk to an Insured Person's life or long-term health.

MEDICALLY NECESSARY or MEDICAL NECESSITY means services or supplies that the treating Physician determines, recommends, approves, and certifies to be:

1. appropriate, necessary, and reasonable for the symptoms, diagnosis or direct care and treatment of an Injury, Arterial Gas Embolism or Decompression Sickness; and,
2. provided for the symptoms, diagnosis or direct care and treatment of an Injury, Arterial Gas Embolism or Decompression Sickness; and,
3. within standards of good medical practice within the organized medical community; and,
4. not primarily for the convenience of the Insured Person, Insured Person's Physician, or another provider; and
5. the most appropriate supply or level of service that can safely be provided.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Insured Person is receiving or the severity of the Insured Person's condition and that Outpatient Treatment would not be adequate to effectively treat the Insured Person.

NURSE means a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) or other healthcare practitioner providing nursing services who, is licensed or certified to provide such services in the country or district where the services are rendered.

OTHER MEDICAL EXPENSE INSURANCE means medical expense insurance provided by any other insurance or welfare plan or prepayment arrangements, regardless of whether the other insurance is provided on an individual, family, or group basis, or through an employer, union, or membership in an association. If insurance is provided on a provision of service basis, then, for purposes of this definition, the amount shall be that which the services rendered would have cost in the absence of the insurance. Other Medical Expense Insurance shall also mean liability coverage, including but not limited to personal umbrella type plans or automobile medical plans.

OUTPATIENT TREATMENT means Medically Necessary services and supplies provided to the Insured Person in a Physician's office or Outpatient department of a Hospital for which no room and board charge is made.

PHYSICIAN means a duly licensed health care provider in good standing acting within the scope of his license and rendering care or treatment to the Insured Person, including:

1. a medical practitioner licensed to provide medical services and perform general surgery; or
2. any other practitioner whose services, by law of the place where such services are performed, must be covered by the Policy.

"Physician" does not include an Immediate Family Member, nor does it include a traveling companion or an employee, business partner or business affiliate of the Insured Person.

POLICY means the contract issued to the Insured Person providing the benefits specified herein.

POLICYHOLDER is DAN World, Ltd. ("DAN").

PRE-EXISTING CONDITION means a sickness, disease, or other condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a Physician during the 180-day period immediately prior to the Insured Person's effective date, including:

1. any recommendation for a diagnostic test, examination, or medical treatment; or

2. conditions for which the Insured Person took or received a prescription for drugs or medicine.
3. a condition for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment prior to embarking on a trip.

Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 180-day period before Coverage is effective under the Policy.

REASONABLE AND CUSTOMARY CHARGE means charges for medically necessary services and supplies provided to the insured that are not more than what is paid (i) locally, where more than one treatment facility exists; or (ii) in other comparable localities where a single treatment facility exists. The nature and severity of the condition will be taken into account.

SICKNESS means an illness or disease of the body which:

1. requires examination and treatment by a Physician, and
2. commences while the Coverage is in effect; and
3. in those cases where the benefit is conditioned upon the Insured Person's inability to dive, in the opinion of a Physician would prevent the Insured Person from diving.

THIRD PARTY (IES) means anyone other than:

1. the Insured Person;
2. a person related to the Insured Person by blood, marriage or adoption;
3. the owners, shareholders, staff members or others who are associated with the business which provided the diving services to the Insured Person.

TRIP means:

1. a period of round-trip travel that is at least eighty (80) kilometers from the Insured Person's home;
2. scheduled duration of travel may not exceed 90 consecutive days;
3. travel is not to obtain health care or medical treatment of any kind; and
4. travel is not to a destination where the Insured Person maintains a Home or residence.

EMERGENCY MEDICAL TRANSPORTATION BENEFITS

Emergency Evacuation and Medically Necessary Transfer

If an Insured Person has suffered a Medical Emergency during the course of a Trip and such condition requires an Emergency Evacuation or Medically Necessary Transfer, the Company will pay, up to the Benefit Limit, the Covered Expenses incurred for such evacuation or transfer.

Emergency Evacuation means when there is no local medical care available and the medical condition of the Insured Person and Medical Necessity warrants immediate Transportation from the place where the Medical Emergency occurs to the nearest Hospital or medical facility where appropriate medical care, treatment or evaluation can be obtained. Emergency Evacuation does not include efforts to search for an Insured Person whose location is unknown or efforts to rescue such Insured Persons from a dangerous situation or a location inaccessible by emergency medical services personnel.

Medically Necessary Transfer means that following treatment or evaluation at the nearest Hospital or medical facility, and absent suitable local care, Medical Necessity warrants Transportation to a different Hospital or medical facility for further care, treatment, or evaluation.

Repatriation of Mortal Remains

If an Insured Person has died while on a Trip, the Company will pay, up to the Benefit Limit, the expenses incurred to move the body and return the mortal remains to the Insured Person's Home for burial. Covered expenses include, but are not limited to, expenses for embalming, cremation, necessary government authorizations, coffins, and Transportation. Expenses related to the use of an air ambulance for the Repatriation of Mortal Remains are expressly excluded.

Repatriation for Additional Care

When an Insured Person suffered a Medical Emergency during the course of a Trip for which Emergency Evacuation or Medically Necessary Transfer is necessary, and the Insured Person is deemed medically fit to travel to a different Hospital or medical facility for further care, treatment, or evaluation, the Company will pay, up to the Benefit Limit, the Covered Expenses for Transportation to a Hospital or medical facility that is located either:

1. near the Insured Person's Home; or,
2. near where the Insured Person was living and/or working prior to their Trip.

Any Repatriation for Additional Care shall be undertaken at the discretion of the designated Travel Assistance Provider in consultation with the Insured Person's treating Physician. Repatriation for Additional Care is limited to scheduled commercial airlines, watercraft, or ground transportation, and the Company will pay, up to the Benefit Limit, the Covered Expenses for such scheduled commercial airlines, watercraft, or ground transportation.

Local Burial

If an Insured Person has died while on a Trip and the family chooses a local burial, the Company will pay, up to the Benefit Limit, for expenses incurred to bury the Insured Person in the place where they died. Covered expenses include, but are not limited to, expenses for embalming, cremation, necessary government authorizations and coffins.

Emergency Medical Transportation Covered Expenses

Covered Expenses include the cost of Transportation and the Reasonable and Customary charge for en route medical treatment, medical services and medical supplies that: (1) is necessarily incurred in connection with Emergency Medical Transportation of the Insured Person or; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance method being used to transport the Insured Person.

All Transportation arrangements made for transporting the Insured Person must be by the most direct and economical conveyance and must be arranged in advance by the designated Travel Assistance Provider to be covered. the Company will not provide Transportation to the Insured Person's Home if there are closer medical facilities which are capable of attending to the Insured Person's medical needs.

Transportation means any land, water, or air conveyance required to transport an Insured Person during medical transportation, transfer, evacuation, or repatriation. Transportation must be required by the circumstances, recommended by local medical personnel and authorized by the designated Travel Assistance Provider. Transportation may include, but is not limited to, air ambulances, land ambulances, private motor vehicles, watercraft, commercial airliner, or train (depending on the circumstances). The designated Travel Assistance Provider will arrange Transportation using the mode best suited to do so based on the seriousness of the patient's condition. All decisions as to the mode of Transportation and final destination will be based solely upon medical factors. the Company will not cover any expenses for services provided by another party at no cost to the Insured Person.

DIVE ACCIDENT MEDICAL EXPENSE BENEFITS

Dive Accident Medical Expense Benefit

Covered Diving Accidents - Covered Medical Expenses

If the Insured Person has incurred charges for treatment of Injury due to a Covered Diving Accident, the Company will pay, up to the Benefit Limit, for the Covered Charges described below subject to the terms and limitations contained herein.

COVERED CHARGES means eligible expenses that are incurred by the Insured Person for Medically Necessary services, supplies, care, or treatment for a Covered Diving Accident. The Accident must occur while Coverage is in force. Eligible expenses must be incurred within 365 days of the Accident.

Medical services, supplies, care, or treatment must be prescribed, performed, or ordered by a Physician. Charges for such services, supplies, care, or treatment must be Reasonable and Customary and the Company will not pay for charges in excess of the Benefit Limit.

Covered Charges include the following:

1. Hyperbaric Chamber treatment charges for up to 3 treatments per Covered Diving Accident. Any treatment after the third (3rd) must be approved by the Company, or its designee, and may require examination by a medical professional designated by the Company.
2. Physician's charges for Hyperbaric Chamber treatment, medical care, and surgical procedures.

3. Ambulance charges for transportation by a professional ground, air or marine ambulance service to the nearest Hospital or Hyperbaric Chamber where appropriate care or treatment can be given. All transportation involving air or marine ambulance service must be approved in advance by the Company or its designee. This benefit may not be combined with any Emergency Medical Transportation benefit.
4. Hospital charges may include room and board; general nursing care; other Inpatient and Outpatient Treatment services and supplies; and confinement in an Intensive Care Unit as long as such confinement is ordered by a Physician.

The daily Hospital allowance payable for room and board for each day of Hospital confinement shall not exceed the average semi-private room rate for the Hospital where confined. If the Hospital where confined has only private rooms, the daily Hospital allowance will be 80% of the private room rate.

The daily Intensive Care Unit allowance payable for room and board for each day of confinement in an Intensive Care Unit is two times the daily Hospital allowance.

5. Medical supply charges for oxygen and anesthesia, including their administration, when these are not covered as Hospital charges;
6. Other eligible expenses including ambulatory surgical charges provided by a licensed ambulatory surgical center for necessary services and supplies, provided such charges would have been payable if the surgery had been done in a Hospital;
7. Nursing, physiotherapy, and occupational therapy charges;
8. Radiological and laboratory charges for X-rays, radiological treatment, and diagnostic laboratory tests;
9. Medical supply charges for: casts, splints, trusses, braces, crutches, and surgical dressing; artificial eyes and limbs for the initial replacement of natural eyes and limbs severed while insured; and,
10. Rental of manually operated wheelchairs and hospital beds, oxygen equipment and other durable medical equipment that is used solely by the Insured Person for the treatment of the Injury. The Company, at its discretion, may approve purchase of such items.

GENERAL EXCLUSIONS

The following exclusion applies to all benefits for Accidental Death and Dismemberment or Permanent and Total Disability:

1. The Company will not pay for loss caused by or resulting from Sickness of any kind.

The following exclusion applies to the Sickness and Accident Medical Expense, Permanent and Total Disability, Trip Cancellation, and Trip Interruption:

1. The Company will not pay for loss or expense caused by or incurred resulting from a Pre-Existing Condition, as defined in the Policy, including death that results there from.

The following exclusions apply to all Emergency Medical Transportation and Travel Assistance Benefits:

1. Emergency Medical Transportation and Travel Assistance Benefits may be suspended if the Insured Person (a) is in a region that is not safely accessible by the company providing the Transportation services; or (b) the Insured Person cannot be transported safely.

The following exclusions apply to **all** coverages.

1. The Company will not pay for any loss under the Policy where:
 - a. the charges exceed Reasonable and Customary Charges for the services and supplies furnished.
2. Excluded from this Policy are losses caused by, resulting from, or in connection with:
 - a. suicide, attempted suicide, or intentionally self-inflicted injury of the Insured Person, while sane or insane, including mental, nervous, or psychological disorders, or if the primary diagnosis is psychiatric in nature;
 - b. being under the influence of drugs or intoxicants, unless prescribed by a Physician;
 - c. pregnancy, childbirth, elective or Medically Necessary abortion, or Complications of Pregnancy;
 - d. participation as a professional in athletics;
 - e. unless approved in advance by the Policyholder, participation in organized amateur and interscholastic athletic or sports competition or events;
 - f. riding or driving in any motor competition;
 - g. war or any act of war, declared or undeclared war, civil disorder, or service in the armed forces, National Guard or organized reserve corps or any country or international authority; however, does not include terrorism;
 - h. nuclear reaction, radiation or radioactive contamination;
 - i. air travel (other than regularly scheduled airlines or air charter services) or operating or learning to operate any aircraft, as pilot or crew;
 - j. unless approved in advance by the Policyholder, mountain climbing, bungee cord jumping, snow skiing, skydiving, parachuting, hang gliding, parasailing, or travel on any air supported device, other than on a regularly scheduled airline or air charter company;
 - k. unless approved in advance by the Policyholder, in connection with competitions or record-setting or record-breaking attempts;
 - l. any unlawful criminal acts, committed by the Insured;
 - m. losses which are paid under Other Medical Expense Insurance, workers' compensation or occupational disease laws, travel insurance, or any services, supplies, or treatments provided under any federal, state or other governmental plan or similar law;
 - n. a loss or damage caused by detention, confiscation or destruction by customs;
 - o. traveling or engaging in a Covered Dive against the advice of a Physician;

- p. Elective Treatment and Procedures;
- q. when the Insured Person is on an organ transplant list at the time he or she embarked on his or her Trip and the requested benefits are related to such transplant;
- r. medical treatment during or arising from a trip undertaken for the purpose or intent of securing medical treatment;
- s. medical services, supplies, or treatment (including any period of Hospital confinement) that were not Medically Necessary, not prescribed by a Physician, deemed to be research or experimental or not recognized as generally accepted medical practice, or were ordered and/or prescribed by an Immediate Family Member;
- t. Custodial Care;
- u. routine eye, hearing, or other physical exams not related to the Sickness or Accident;
- v. cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance but do not restore or improve impaired physical functions;
- w. Financial Insolvency of the person, organization or firm from whom the Insured Person directly purchased or paid for his/her trip;
- x. bankruptcy, Financial Insolvency, default or failure to supply services by a travel supplier;
- y. business, contractual or educational obligations of the Insured Person;
- z. failure of any tour operator, common carrier, liveaboard, or other travel supplier, person or agency to provide the bargained-for travel arrangements other than Financial Insolvency;
- aa. a loss that results from an illness, disease, or other condition, event or circumstance which occurs at a time when the Policy is not in effect for the Insured Person; and,
- bb. for services, supplies, treatment, or transport related to a pandemic, epidemic, or exposure to a contagious infectious disease that was known to the public prior to the time the Insured Person embarked on their Trip.

CLAIMS PROVISIONS

Notice of Claim. The Company must be given written notice of claim within ten (10) days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. Notice may be given to the Company or to its authorized agent. To submit a claim, obtain claim forms, or request additional information on how to report a claim, please call, write or email:

AGI - CLAIMS

c/o DAN Services, Inc.
 6 West Colony Place, Suite 200
 Durham, NC 27705 USA
 Phone: +1.919.226.3858
 Email – Claims@World.DAN.org

How to File a Claim.

1. Complete the claim form in full. Please answer all questions completely. If you don't, the claim may have to be returned to you and delay settlement of your claim. Be sure to sign the claim form.
2. Ask the hospital and/or doctor to complete the reverse side of the form and return it to you. (The provider can attach an itemized bill instead.)
3. Attach any other bills, documents or statements that apply to the claim. It is important that they contain the right information.
4. Make copies of your forms and bills for your records — your originals will not be returned to you.
5. If you received a payment from any other Insurance, you must send the Explanation of Benefits with your bills before your claim can be settled.

Please forward these documents to AGI - CLAIMS at the address above or by email to Claims@World.DAN.org. DAN World program benefits are subject to change following 30 days' notice to existing clients. All amounts shown are in US dollars.

Claim Forms. When the Company receives notice of claim, the Insured Person will be sent forms to file proof of loss. If the forms are not sent within 15 days after the Company receives notice, then the claimant will meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss. This must be sent to the Company within the time limit stated in the Proof of Loss provision.

Notice of Claim. The Company must be given written notice of claim within 180 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. Notice may be given to the Company or to its authorized agent. Notice should include the Insured Person's name and enough information to identify and contact him/her.

Payment of Claims. Benefits for loss of life of an Insured Person will be paid in accordance with the beneficiary designation, or if none to the Insured Person's estate. Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid, to the Insured Person's estate or at the Company's option, in equal shares, to the survivors in the first surviving class of those that follow: The Insured Person's (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

Payment to a Minor or Incompetent. If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding US\$3,000 may be made, at the option of the Company, to any relative by blood or connection by marriage of the payee, who, in the opinion of the Company, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Proof of Loss. Written Proof of Loss must be sent to the Company within 180 days after the date the loss occurs. The Company will not reduce or deny a claim if it was not reasonably possible to give written Proof of Loss within the time allowed. In any event, the Insured Person must give the Company written Proof of Loss within 12 months after the date the loss occurs unless the Insured Person is legally incapacitated.

Time of Payment of Claim. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid within 90 days of receipt of due written proof of such loss. Subject to due written proof of loss, all benefits that accrue for loss for which the Policy provides periodic payment will be paid monthly.

GENERAL PROVISIONS

ENTIRE CONTRACT

The application, group policy, certificate, and any attached riders shall form the entire contract between us. Any statement the Insured Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of any written application or enrollment form.

EXAMINATION UNDER OATH

As often as we may reasonably require, the Insured Person or any person making a claim under this Policy must submit to examination under oath.

BENEFICIARY: CHANGE OF BENEFICIARY

The Insured Person will name the beneficiary at the time of enrollment. The Insured Person may change the beneficiary at any time. To do so, a written request on a form satisfactory to the Company must be made to its home office. When the Company records the change, it will take effect as of the date signed. The change will not apply to any payment made by the Company before the request was recorded. If two (2) or more beneficiaries are named and their shares are not specified, they will share the proceeds equally.

When an Insured Person dies, there may be no living named beneficiary to receive any part of the proceeds. If so, the Company may pay such proceeds to the Insured Person's estate or, at the Company's option, to the Insured Person's:

- spouse, if living
- surviving children, equally, if the spouse is dead, or
- surviving parents, equally, if all children are dead.

The Company will not be liable for such payment after it is made.

MULTIPLE CERTIFICATES

A person cannot be insured under more than one certificate providing the same type of insurance coverage under group policies issued by the Company to the Policyholder and/or its affiliates. Coverage will be in effect under only one certificate at any one time. Premium paid for certificates which are not in effect will be refunded.

MISSTATEMENT OF AGE

If premiums and/or benefits for the Insured Person are based on age and the Insured Person's age has been misstated, there will be a fair adjustment of premiums and/or benefits based on the Insured Person's true age. The Company may require satisfactory proof of age before paying any claim.

EXCESS PROVISION

The Benefits under the Policy, other than those noted above, are excess over any other valid and collectible insurance, including but not limited to, Other Medical Expense Insurance and travel insurance, available to the Insured for a covered loss under the Policy. If an Insured receives or is entitled to receive benefits or services from any other valid and collectible insurance for any eligible benefit category of a covered loss for which he or she is entitled under the Policy, such benefit under the Policy will be in excess of the amount of such other valid and collectible insurance.

Benefits payable will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance whether or not a claim is made for such benefits. For purposes of the Policy, an Insured's entitlement to other valid and collectible insurance will be determined as if the Policy did not exist and shall not depend upon whether timely application for other valid and collectible insurance is made by or on behalf of the Insured. If the other valid and collectible insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose coverage has been in effect for the longer period of time.

RIGHT OF RECOVERY

As a condition to receiving benefits under the Policy, other than the benefits noted above, the Insured (or, if he or she is deceased, an authorized representative of the Insured) agrees, except as may be limited or prohibited by applicable law:

1. to reimburse the Company for any such benefits paid to or on behalf of the Insured, if such benefits are recovered, in any form, from any Third Party or Coverage; and
2. without limiting the preceding, that the Company is subrogated, for the purpose of the Company's recovery of any such benefits paid to or on behalf of the Insured Person, to any and all claims, causes of action or rights that he or she has or that may rise against any Third Party who has or may have caused, contributed to or aggravated the injury or condition for which the Insured Person claims an entitlement to Policy benefits, and to any claims, causes of action or rights he or she may have against any Coverage for the injury or condition for which the Insured Person claims an entitlement to Policy benefits.

The Insured Person agrees that he or she will make a decision on pursuing any and all claims, causes of action and rights against any and all Third Parties and Coverage within 30 days of the date the Company requires that the Insured Person provide Notice of Claim for the injury or condition for which such Policy benefits are sought, and within such 30-day period will so notify the Company in writing. In the event the Insured Person decides not to pursue a claim, cause of action or right against a Third Party or Coverage, or fails to notify the Company of his or her intent to do so within such 30-day period, the Insured Person authorizes the Company to pursue, sue, compromise or settle any such claim, cause of action or right in his or her name, authorizes the Company to execute any and all documents necessary to pursue any such claim, cause of action or right, and agrees to cooperate fully with the Company in the prosecution of any such claim, cause of action or right.

If the Insured is a minor or is not competent to make this agreement, the legal guardian of the Insured's property makes the agreement on the Insured's behalf as a condition to receiving benefits under the Policy on behalf of the Insured. If the Insured has no guardian for his or her property, the person or persons who, in the Company's opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on the Insured's behalf as a condition to receiving such benefits under the Policy on behalf of the Insured.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of the Insured Person against any Third Party or Coverage. The Company will not be entitled to recover for any benefits paid to or on behalf of the Insured Person until after the Insured Person has been fully compensated for the loss sustained. For purposes of this Right of Recovery Provision Only:

Coverage means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy (except the Policy and any fund or insurance policy providing the Policyholder with coverage for any claims, causes of action or rights the Insured may have against the Policyholder).

Third Party(ies) means any person, corporation, or other entity (except the Insured, the Policyholder, and the Company).