

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

MASTER APPLICATION FOR BLANKET ACCIDENT INSURANCE POLICY

Application is hereby made for a plan of accident insurance based on the following statements and representations:

1. **Identification of Policyholder:**

Name of Policyholder: Kiwanis International

Address of Policyholder: 3636 Woodview Trce, Indianapolis, IN 46268

Policy Number: SRG 0009126909

2. **Classification of Eligible Persons:**

Class Description of Class

I All Volunteers and participants whose names are on file with the Policyholder.

Number of Eligible Persons: To Be Determined

3. **Policy Coverage:**

A. **Covered Activities:**

While participating in Kiwanis sponsored events, including but not limited to special events, fairs and fund raisers.

B. **Benefit Schedule:**

CLASS I

Accidental Death Benefit

Maximum Amount: \$25,000

Accidental Dismemberment Benefit

Maximum Amount: \$25,000

Accident Medical Expense Benefit

Maximum Amount: \$25,000

Deductible: \$50 per accident

Dental Maximum: \$250 per tooth per accident to a maximum of \$1,000.

The Maximum Amounts are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

Aggregate Limit \$250,000

C. Policy Riders and/or Endorsements:

The following Riders and/or Endorsements are attached to and made part of the Policy as of the Policy Effective Date. Each Rider and/or Endorsement is subject to all provisions, limitations and exclusions of the Policy that are not specifically modified by the Rider and/or Endorsement.

FORMS NO	DESCRIPTION	CLASS(ES)
C11699DBG	Accident Medical Expense Benefit	I
C11704DBG	Excess Benefits with Integrated Deductible	I
C11716DBG	Subrogation and Right of Recovery	I
S30399DBG	Injury Definition And Exclusions Amendatory Endorsement	I

4. **Premiums:**

It is understood and agreed that the premium rate per participant per year shall be \$3.50.

5. **Policy Effective Date:** January 1, 2010

6. **Policy Termination Date:** Continuous until canceled

Signed for the Policyholder

Title

Date

Signed by Licensed Resident Agent
(Where Required by Law)

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Policyholder: Kiwanis International

Policy Number: SRG 0009126909

BLANKET ACCIDENT INSURANCE POLICY

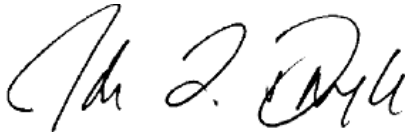
This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder against loss covered by this Policy subject to its provisions, limitations and exclusions. The persons eligible to be Insureds are all persons described in the Classification of Eligible Persons section of the Master Application. This Policy provides accident insurance to Insureds while they are participating in Covered Activities.

This Policy is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Master Application, which is attached to and made part of this Policy.

This Policy begins on the Policy Effective Date shown in the Master Application and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent of the Company and the Policyholder at the premium rates set by the Company for the renewal period.

This Policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Policy:



President



Secretary

PLEASE READ THIS POLICY CAREFULLY.

Non-Participating Policy

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DEFINITIONS

Any capitalized terms in the Policy, Master Application, and any riders, amendments, or other attached papers are to be given the meanings as ascribed in this section or as later defined.

Benefit Schedule - means the Benefit Schedule section of the Master Application.

Covered Activity (ies) - means those activities set out in the Covered Activities section of the Master Application, with respect to which Insureds are provided accident insurance under this Policy.

Injury - means bodily injury caused by an accident that: (1) occurs while this Policy is in force as to the person whose injury is the basis of claim; (2) occurs while such person is participating in a Covered Activity; and (3) results directly and independently of all other causes in a covered loss.

Insured - means a person: (1) who is a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; (2) for whom premium has been paid; and (3) while covered under this Policy.

Immediate Family Member - means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Physician - means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

POLICY EFFECTIVE AND TERMINATION DATES

Effective Date. This Policy begins on the Policy Effective Date shown in the Master Application at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Termination Date. Either the Company or the Policyholder may terminate this Policy, on any premium due date by giving 30 days advance notice in writing to the other party. This Policy may, at any time, be terminated by mutual written consent of the Company and the Policyholder. This Policy terminates automatically on the earlier of: 1) the Policy Termination Date shown in the Master Application; or 2) the premium due date if premiums are not paid when due. Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

INSURED'S EFFECTIVE AND TERMINATION DATES

Effective Date. An Insured's coverage under this Policy begins on the latest of: (1) the Policy Effective Date; (2) the date for which the first premium for the Insured's coverage is paid; or (3) the date the person becomes a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application.

A change in an Insured's coverage under this Policy due to a change in his or her eligible class or Covered Activity becomes effective on the later of: (1) when the change in his or her eligible class or Covered Activity occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to accidents that occur once the change becomes effective.

Termination Date. An Insured's coverage under this Policy ends on the earliest of: (1) the date this Policy is terminated; (2) the premium due date if premiums are not paid when due, or (3) the date the Insured ceases to be a member of any eligible class(es) of persons as described in the Classification of Eligible Persons section of the Master Application.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under this Policy.

PREMIUM

Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premiums section of the Master Application. The Company may change the required premiums as a condition of any renewal of this Policy. The Company may also change the required premiums at any time when any change affecting rates is made in this Policy. (Any such change in this Policy will not take effect until any required additional premium is received by the Company, except as otherwise agreed to in writing by the Company and the Policyholder.)

Grace Period. A Grace Period of 31 days will be provided for the payment of any premium due after the first. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If the Company expressly agrees to accept late payment of a premium without terminating this Policy, the Company does so in accordance with the Noncompliance with Policy Requirements provision of the General Provisions section. In such case, the Policyholder will be liable to the Company for any unpaid premiums for the time this Policy is in force.

No grace period will be provided if the Company receives notice to terminate this Policy prior to a premium due date.

BENEFITS

Maximum Amount. As applicable to each Benefit provided by this Policy for each Insured, Maximum Amount means the amount shown as the maximum amount for that Benefit for the Insured's eligible class in the Benefit Schedule.

Accidental Death Benefit. If Injury to the Insured results in death within 365 days of the date of the accident that caused the Injury, the Company will pay 100% of the Maximum Amount.

Accidental Dismemberment Benefit. If Injury to the Insured results, within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Maximum Amount shown below for that Loss:

For Loss of	Percentage of Maximum Amount
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot.....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye.....	50%
Speech or Hearing in Both Ears	50%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance. If by reason of an accident occurring while an Insured's coverage is in force under this Policy, the Insured is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under this Policy, the loss will be covered under the terms of this Policy.

If the body of an Insured has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured has suffered accidental death within the meaning of this Policy.

LIMITATIONS

Limitation on Multiple Benefits. If an Insured suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided by this Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit.

Aggregate Limit. The maximum amount payable under this Policy may be reduced if more than one Insured suffers a loss as a result of the same accident, and if amounts are payable for those losses under one or more of the following Benefits provided by this Policy: Accidental Death Benefit, Accidental Dismemberment Benefit. The maximum amount payable for all such losses for all Insureds under all those Benefits combined will not exceed the amount shown as the Aggregate Limit in the Benefit Schedule. If the combined maximum amount otherwise payable for all Insureds must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each Insured for all such losses under all those Benefits combined.

EXCLUSIONS

This Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.
3. the Insured's commission of or attempt to commit a felony.
4. declared or undeclared war, or any act of declared or undeclared war.
6. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned Premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after an Insured's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at AIG Domestic Claims, Inc. A&H Claims Department, PO Box 25987, Shawnee Mission, KS, 66225, with information sufficient to identify the Insured, is deemed notice to the Company.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured will be made, in equal shares, to the survivors in the first surviving class of those that follow: the Insured'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.

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 suffering the loss. If an Insured dies before all payments due have been made, the amount still payable will be paid, in equal shares, to the survivors in the first surviving class of those that follow: the Insured'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.

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 \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

GENERAL PROVISIONS

Entire Contract; Changes. This Policy, the Master Application, and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured will be considered representations and not warranties. No written statement made by an Insured will be used in any contest unless a copy of the statement is furnished to the Insured or his or her beneficiary or personal representative.

No change in this Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Incontestability. The validity of this Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

Physical Examination and Autopsy. The Company at its own expense has the right and opportunity to examine the person of any individual whose loss is the basis of claim under this Policy when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

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 this Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Workers' Compensation. This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured if that insurance would otherwise have been in effect nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy.

Records. The Company has the right to inspect at any reasonable time, any records of the Policyholder that may have a bearing on this insurance.

Assignment. This Policy is non-assignable. An Insured may assign all of his or her rights, privileges and benefits under this Policy. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this Policy.

New Entrants. This Policy will allow from time to time, that new eligible Insureds of the Policyholder be added to the class(es) of Insureds originally insured under this Policy.

Misstatement of Age. If premiums for the Insured are based on age and the Insured has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured is insured are based on age and the Insured has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

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Policyholder: Kiwanis International

Policy Number: SRG 0009126909

ACCIDENT MEDICAL EXPENSE BENEFIT RIDER

This Rider is attached to and made part of the Policy effective November 1, 2009. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

Accident Medical Expense Benefit. If an Insured suffers an Injury that, within 90 days of the date of the accident that caused the Injury, requires him or her to be treated by a Physician, the Company will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Amount per Insured for all Injuries caused by the same accident. This benefit is payable only for such charges incurred after the Deductible has been met and within 52 weeks after the date of the accident causing that Injury.

Covered Accident Medical Service(s) - as used in this Rider, means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician or a registered nurse (R.N.);
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. physical therapy and occupational therapy;
9. rental of Durable Medical Equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances; or
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription.

Ambulatory Medical Center - as used in this Rider, means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Deductible - as used in this Rider, means the amount of Usual and Customary Charges for Medically Necessary Covered Accident Medical Services that must be incurred by the Insured due to Injuries resulting from an accident before Accident Medical Expense benefits become payable due to Injuries resulting from that accident. The amount of the Deductible is the Deductible Amount shown in the Benefit Schedule. Accident Medical Expense benefits are not payable for charges applied to the Deductible.

Durable Medical Equipment - as used in this Rider, refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Hospital - as used in this Rider, means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s), and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary - as used in this Rider, means that a Covered Accident Medical Service is: (1) essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

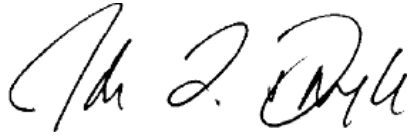
Usual and Customary Charge(s) - as used in this Rider, means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

Exclusions. In addition to the Exclusions in the Exclusions section of the Policy, Accident Medical Expense benefits are not payable for, and Usual and Customary Charges for Covered Accident Medical Services do not include, any expense for or resulting from any of the following:


1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition.
2. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost as a result of Injury up to the Dental Maximum shown in the Benefit Schedule.
3. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight.
4. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing.
5. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense in lieu of such rental expense).

6. personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
7. any condition for which the Insured is entitled to benefits under any Workers' Compensation Act or similar law.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:



President



Secretary

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EXCESS BENEFITS WITH INTEGRATED DEDUCTIBLE RIDER

This Rider is attached to and made part of the Policy effective November 1, 2009. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

Excess Benefits with Integrated Deductible. This Rider applies when an Insured has Accident Medical Expense coverage (herein called This Plan) under the Policy and health care coverage under one or more other Plans. When there is a basis for a claim under This Plan and another Plan, This Plan is an excess plan which has its benefits determined in excess of the benefits of the other Plan as described below, unless both: (1) the other Plan has coordination or excess benefits rules that require its benefits to be determined in excess of the benefits of This Plan; and (2) This Plan has covered the Insured longer than the other Plan has. When This Plan is an excess plan, the benefits of This Plan for any Allowable Expenses will be reduced when the sum of:

1. the benefits that would be payable for those Allowable Expenses under This Plan in the absence of this Rider; and
2. the benefits that would be payable for those Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of a coordination or excess benefits provision, whether or not claim is made;

exceeds the amount of those Allowable Expenses. In that case, This Plan's benefits will be reduced so that they and the other Plans' benefits do not total more than the amount of those Allowable Expenses.

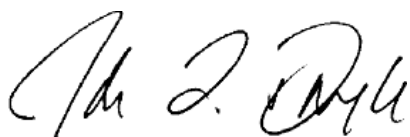
Right to Receive and Release Needed Information. The Company has the right to decide which facts it needs to administer this Rider. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to pay the claim.

Facility of Payment and Right of Recovery. If a payment made under another Plan includes an amount that should have been paid under This Plan, the Company may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Company is more than it should have paid under this Rider, it may recover the excess from the persons it has paid or for whom it has paid, insurance companies or other organizations.

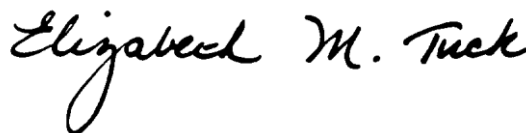
Plan - as used in this Rider, means any of the following group, group-type (such as, but not limited to, franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies; (2) subscriber contracts; (3) uninsured arrangements; (4) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans; (5) medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts; and (6) coverage under a governmental plan or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Allowable Expense - as used in this Rider, means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by the Policy and is covered at least in part by one or more other Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid, if the reasonable cash value had been charged as the cost for the service and such expense would have been covered at least in part by the Policy.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:



President



Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

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Policy Number: SRG 0009126909

SUBROGATION AND RIGHT OF RECOVERY ENDORSEMENT

This Endorsement is attached to and made part of the Policy effective November 1, 2009. It applies only with respect to benefits payable under the Policy on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

The following section is added after the Exclusions section of the Policy:

SUBROGATION AND RIGHT OF RECOVERY

As a condition to receiving Accident Medical Expense benefits under this Policy, 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, 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 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 claims an entitlement to Policy benefits.

The Insured 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 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 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 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 Accident Medical Expense benefits under this 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 this 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 an Insured against any Third Party or Coverage.

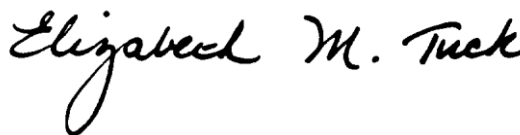
Coverage - as used in the Subrogation and Right of Recovery section of this Policy, means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy (except this Policy and any fund or insurance policy providing the Policyholder with coverage for any claims, causes of action or rights the Insured may have against the Policyholder).

Third Party(ies) - as used in the Subrogation and Right of Recovery section of this Policy, means any person, corporation or other entity (except the Insured, the Policyholder and the Company).

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:



President



Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: Kiwanis International

Policy Number: SRG 0009126909

INJURY DEFINITION AND EXCLUSIONS AMENDATORY ENDORSEMENT

This Endorsement is attached to and made part of this Policy effective November 1, 2009. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of this Policy except as they are specifically modified by this Endorsement.

1. The definition of Injury in the Definitions section of this Policy is deleted and replaced by the following:

Injury – means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that occurs while the injured person's coverage under this Policy is in force; and (2) which occurs while such person is participating in a Covered Activity; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

2. The Exclusions section of the Policy is deleted and replaced by the following:

EXCLUSIONS

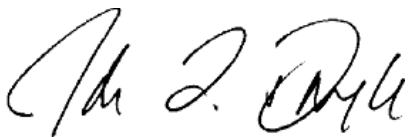
No coverage shall be provided under this Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury.

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or auto-eroticism.
2. sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
3. the Insured Person's commission of or attempt to commit a felony.
4. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
5. declared or undeclared war, or any act of declared or undeclared war, except if specifically provided by this Policy.
6. participation in any team sport or any other athletic activity, except participation in a Covered Activity.
7. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while

on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.).

8. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Person is:
 - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
 - c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Insured Person's employer.
9. the Insured being under the influence of intoxicants.
10. the Insured being under the influence of drugs unless taken under the advice of and as specified by a Physician.
11. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.
12. stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.
13. any condition for which the Insured is entitled to benefits under any Workers' compensation Act or similar law.
14. the Insured riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.
15. any loss incurred while outside the United States, its Territories or Canada.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa witness this Endorsement:



President



Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

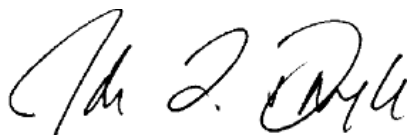
THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement, effective November 1, 2009 12:01 A.M. forms a part of Policy No.: SRG 0009126909 issued to Kiwanis International by National Union Fire Insurance Company of Pittsburgh, PA.

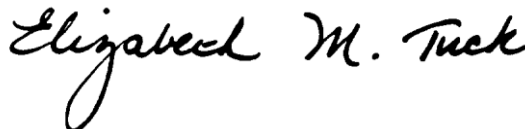
COVERAGE TERRITORY ENDORSEMENT

This endorsement modifies insurance provided under the following:

Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").



President



Secretary

Domestic Accident & Health Division

Privacy Notice

Administrative Offices
600 King Street, Wilmington, DE 19801

Our Customers' Privacy Is Important to Us

We are committed to providing individuals covered by our accident and health insurance policies (our "Customers") with top-notch products backed by top-quality customer service. While information is fundamental to our ability to do this, we recognize the great importance of keeping our Customers' non-public personal information secure. Accordingly, we, the Domestic Accident & Health Division of the AIG CompaniesSM listed below, have established practices and procedures with respect to the collection and sharing of our current and former Customers' non-public personal financial and health information ("Customer Information").

Information Collection

We may collect information about our Customers from enrollment forms, applications, transactions, and other interactions with us or our affiliates, as well as from credit reporting agencies and other third parties. We will collect and disclose this information only in accordance with applicable laws or regulations or in response to our Customer's request for a product or service from us. The information we gather helps us identify who our Customers are, manage our relationship with them, and develop products and services that meet their needs.

Information Sharing

We may share Customer Information with third parties under the following circumstances:

- **Affiliates:** We may share Customer Information with our affiliates. These affiliates may include providers of financial services such as other insurance companies, banks, securities broker-dealers, and insurance agents and agencies. They may also include affiliated non-financial entities such as marketing companies, e-commerce service providers, and companies providing administrative services.

We will not share our Customer's non-public personal *financial* information with our affiliates without first providing our Customer an opportunity to direct that such information not be shared. Furthermore, we will not share our Customer's non-public personal *health* information with affiliates except as directed or authorized by our Customer.

- **Non-Affiliates:** We may also share Customer Information with non-affiliated companies for administrative purposes, the purposes of risk management, underwriting, to detect and prevent fraud, as directed or authorized by our Customer, or as otherwise permitted or required by law.

From time to time, we may also enter into joint marketing and/or service agreements to share Customer non-public personal *financial* information with non-affiliated third parties as permitted by law. These third parties may include providers of financial products or services such as insurance companies, financial institutions, and securities firms.

The types of information we may share in these circumstances include identifying information (e.g., name or address) and/or application information. Because we do not share Customer Information in any other way, there is no need for an opt-out process in our privacy procedures.

Information Protection

We maintain physical, electronic, and procedural safeguards designed to protect Customer Information and permit only authorized insurance agents, administrators, and employees who are trained in the proper handling of Customer Information, to have access to that information.

We expect any non-affiliated third party that serves our Customers on our behalf to adhere to our privacy policy. Those third parties are legally bound to use our Customers' Information only for the purposes for which it was provided, and to not disclose it or use it in any way. These third parties are also subject to and governed by federal and state privacy laws and regulations, and we are not responsible for their misuse of information.

To help prevent unwarranted disclosure of your non-public personal information and secure it from theft, we utilize secure computer networks and restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you.

Maintaining Accurate Information

We also maintain procedures to ensure that the information we collect is accurate, up-to-date, and as complete as possible. If you believe the information we have about you in our records or files is incomplete or inaccurate, you may request that we make additions or corrections, or if it is feasible, that we delete this information from our files. You may make this request in writing to (include your name, address and policy number):

Chief Privacy Officer
AIG – Commercial Insurance
175 Water Street, 3rd Floor
New York, NY 10038
E-Mail: AIGCI.Privacy@AIG.com

Special notice for policyholders who reside in any of the following states: Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia or Wisconsin: You can obtain access to any non-public personal information we have about you if you properly identify yourself and submit a written request to us at the address above describing the information you want to review (include your name, address and policy number). Once we have received your request, and if the information is reasonably locatable and retrievable, we will, within 30 business days, take the following actions:

- Inform you of the nature and substance of the recorded information;
- Allow you to see and copy, in person, such recorded personal information; or
- Send you a copy of the recorded personal information by mail (we may charge you a reasonable fee to cover the cost of this service).

We will also tell you at this time the identity, if recorded, of persons to whom we have disclosed the non-public personal information within the preceding two years.

If you ask us to correct, amend or delete any information about you, we will, within 30 business days, either correct, amend or delete the non-public personal information in dispute or notify you of our refusal to take such action along with the reasons for our decision. If we make the correction, amendment or deletion you've requested, we will also notify you along with any person you designate who has received the information about you within the preceding two years, together with any insurance support organization(s) which provided us with the disputed information.

If we refuse to make the requested correction, amendment or deletion, you are permitted to file a concise statement setting forth what you think is the correct, relevant or fair information along with a statement of the reasons why you disagree with our refusal to correct, amend or delete the information subject to dispute. We will file your statement with the disputed personal information and make any person who reviews your file aware of your statement. We will also furnish your statement to any person who has received personal information from us within the two preceding years and any insurance support organization whose primary source of personal information is an insurer.

Important Information Concerning the Applicability and Future Changes to this Privacy Policy

This privacy policy applies, with respect to non-public personal financial information, to products or services provided primarily for personal, family, or household purposes in the United States by the AIG Companies listed below, and it applies to all non-public personal health information these Companies may have. Although we may change this policy at any time, please rest assured that you will be notified of any changes as required by law.

Our Customers Can Depend on Us

We are committed to maintaining our trusted relationship with our Customers. We consider it our privilege to serve our Customers' insurance and financial needs and we value the trust they have placed in us. Our Customers' privacy is a top priority with us and thus we will continue to monitor our privacy practices in order to protect and respect that privacy and will comply with state privacy laws that require more restrictive practices than those set out in this notice.

Domestic Accident & Health Division

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- National Union Fire Insurance Company of Pittsburgh, Pa. • The Insurance Company of the State of Pennsylvania
 - American Home Assurance Company • AIG Life Insurance Company • American International Life Assurance Company of New York
- Subsidiaries of American International Group, Inc.

IMPORTANT NOTICE TO OUR CUSTOMERS REGARDING THE OFFICE OF FOREIGN ASSETS CONTROL

Your rights as a policyholder and payments to you, any insured, additional insured, loss payee, mortgagee, or claimant, for loss under this policy may be affected by the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL ("OFAC").

WHAT IS OFAC?

OFAC is an office of the Department of the Treasury and acts under presidential wartime and national emergency powers, as well as authority granted by specific legislation, to impose controls on transactions and freeze foreign assets under U.S. jurisdiction. OFAC administers and enforces economic embargoes and trade sanctions primarily against:

- Targeted foreign countries and their agents
- Terrorism sponsoring agencies and organizations
- International narcotics traffickers

PROHIBITED ACTIVITY

- OFAC enforces certain embargoes and sanctions against certain designated countries. No U.S. business or person may enter into certain transactions in or connected to such designated "sanctioned" countries.
- OFAC maintains a directory known as the "Specially Designated Nationals and Blocked Persons" ("SDNBP") list. No U.S. business or person may transact business with any person or entity named on the SDNBP list.

Additional and more in-depth information on OFAC is available at the following website:

<http://www.ustreas.gov/offices/eotffc/ofac>.

OBLIGATIONS PLACES ON US BY OFAC

If we determine that you or any insured, additional insured, loss payee, mortgagee, or claimant are on the SDNBP list or are connected to a sanctioned country as described in the regulations enforced by OFAC, we must block or "freeze" property and payment of any funds transfers or transactions and report all blocks to OFAC within ten (10) days.

POTENTIAL ACTIONS BY US

1. We may immediately cancel your coverage effective on the day that we determine that we have transacted business with an individual or entity associated with your policy on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.
2. If we cancel your coverage, you will not receive a return premium unless approved by OFAC. All funds will be placed in an interest bearing blocked account established on the books of a U.S. financial institution.
3. We will not pay a claim, accept premium or exchange monies or assets of any kind to or with individuals, entities or companies (including a bank) on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC. And, we will not defend or provide any other benefits under your policy to individuals, entities or companies on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.

YOUR RIGHTS AS A POLICYHOLDER

If funds are blocked or frozen by us in conjunction with the OFFICE OF FOREIGN ASSETS CONTROL, you may complete an "APPLICATION FOR THE RELEASE OF BLOCKED FUNDS" and apply for a specific license to request their release. Forms are available for download at the OFAC website. See <http://www.ustreas.gov/offices/eotffc/ofac/legal/forms/license.pdf>.