STARR COMPANIES

SCHEDULE OF BENEFITS
Plan: Safe Descents Ski Evacuation

We will provide the coverage described in this Policy and listed below.

BENEFITS	MAXIMUM BENEFIT
Ski Rescue and Evacuation	$25,000 per Insured

The Maximum Benefit shown is an aggregate amount for each Insured for all Covered Activities during the Policy Term.

TERRITORY: This Policy applies to an insured event unless specifically limited by Us through endorsement or where the Insured or any beneficiary or payee under this Policy is a citizen or instrumentality of the government or any country(ies) against which any laws and/or regulations governing this Policy and/or Us have established any embargo or other form of economic sanction which has the effect of prohibiting Us from providing insurance coverage, transacting business with or otherwise offering economic benefits to the Insured or any other beneficiary or payee under this Policy. No benefits or payments will be made to any beneficiary(ies) or payees who is/are declared unable to receive economic benefits under the laws and/or regulations governing this Policy and/or Us.

STARR INDEMNITY & LIABILITY COMPANY
Dallas, Texas

Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

SKIERS RESCUE AND EVACUATION INSURANCE POLICY
Safe Descents Ski Evacuation

This Policy is issued in consideration of the payment of the premium due. This Policy describes all of the rescue and evacuation insurance benefits underwritten by Starr Indemnity & Liability Company, herein referred to as We, Us, and Our. This Policy is a legal contract between You (herein referred to as You or Your) and Us. It is important that You read Your Policy carefully. Insurance benefits vary from program to program. Please refer to the Schedule of Benefits. It provides You with specific information about the program You purchased.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

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SECTION I. GENERAL DEFINITIONS

"Accident" means a sudden, unexpected, unusual, specific event that occurs at an identifiable time and place during a Covered Activity.
"Accidental Injury" means bodily injury caused by an Accident, directly and independently of all other causes and sustained on or after the Effective Date of this coverage and on or before the Expiration Date. Benefits for Accidental Injury will not be paid for any loss caused by sickness or other bodily diseases or infirmity.
"Assistance Company" means the service provider with whom We have contracted to coordinate and deliver emergency travel assistance, emergency medical evacuation and repatriation.
"Backcountry Skiing or Snowboarding" means skiing or snowboarding in unmarked, unpatrolled areas beyond the boundaries of the Ski Resort.
"Complications of Pregnancy" means a condition that is distinct from pregnancy but is adversely affected or caused by pregnancy.
"Covered Activity(ies) means:
(a) riding a ski lift at a Ski Resort for the purpose of skiing or snowboarding;
(b) skiing or snowboarding at a Ski Resort;
(c) participating as an enrollee in ski or snowboard school at a Ski Resort.
"Dependent Child(ren)" means an unmarried child, stepchild, legally adopted child or foster child, who is less than age 18.
"Domestic Partner" means a person, at least 18 years of age, with whom the Insured has been living in a spousal relationship with evidence of cohabitation for at least 6 continuous months prior to the Effective Date of coverage.
"Effective Date" means the date and time the Insured's coverage begins, as outlined in **SECTION III. ELIGIBILITY AND PERIOD OF COVERAGE** of the Policy.
"Emergency Medical Evacuation" means transportation to the nearest Hospital or other medical facility capable of providing appropriate treatment.
"Emergency Medical Evacuation Expenses" means expenses incurred for Medically Necessary transportation, including reasonable and customary medical services and supplies incurred in connection with the Insured's Emergency Medical Evacuation. Expenses for transportation must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting the Insured; (c) reviewed and pre-approved by Our designated

Assistance Company unless the designated Assistance Company could not be contacted; and (d) by the most direct and economical conveyance and route possible, such as air or land ambulance or commercial airline carrier. Emergency Medical Evacuation Expenses shall also include the reasonable and customary expenses for escort expenses required by the Insured if disabled during a Covered Activity and an escort is recommended in writing by an attending Physician. Such expenses must be pre-approved and authorized by Our designated Assistance Company.

"Emergency Treatment" means necessary medical treatment, including services and supplies that must be performed during a Covered Activity due to the serious and acute nature of the Accidental Injury.

"Expiration Date" means the last date the Insured's Lift Ticket is valid during a Covered Activity.

"Extreme Skiing" means any skiing that involves heli-skiing or heli-snowboarding, Backcountry Skiing or Snowboarding or skiing out of the patrolled ski boundaries or on closed trails.

"Field Rescue" means the Insured's rescue and transportation by, or at the direction of, a government agency or authority from the location of the Insured's Accidental Injury to the nearest Hospital or other medical facility for emergency care or treatment. The Field Rescue is to be performed by individuals who have been appointed or requested by a governmental authority within (50) miles of the person's last known location before the requested rescue is activated.

"Field Rescue Expenses" means those reasonable costs incurred for: fuel, operating costs, repair and rental of motor vehicles, aircraft or helicopters, hovercraft, snowmobiles, horses, dogs, generators, and any other equipment or expenses deemed necessary and appropriate to conduct activities designed to recover or rescue the Insured. Field Rescue Expenses must be documented by itemized receipts and costs from such agencies or authority. Field Rescue Expenses do not include any fines, damages, penalties, liability or the costs of any litigation that result from the Insured's activities or actions.

"Hospital" means a facility that:

(a) holds a valid license if it is required by the law;
(b) operates primarily for the care and treatment of sick or injured persons as in-patients;
(c) has a staff of one or more Physicians available at all times;
(d) provides 24-hour nursing service and has at least one registered professional nurse on duty or call;
(e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the Hospital on a prearranged basis;
(f) is not primarily a nursing care facility, rest home, convalescent home or similar establishment or any separate ward, wing or section of a Hospital used as such; and
(g) is not a treatment or rehabilitation facility for drug addiction or alcohol abuse.

"Insured" means a person for whom the required premium has been paid and for whom a Lift Ticket has been purchased.

"Lift Ticket" means a single or multi-day ticket or Season Pass purchased for use to ski and/or snowboard at a Ski Resort. Insurance under this Policy is not transferrable, even if a Lift Ticket or Season Pass is transferrable.

"Lift Ticket Broker" means the entity that sells a Lift Ticket. Lift Ticket Broker may include a Ski Resort, an online broker, or a property management company. Lift Ticket Broker does not include an individual reselling Lift Tickets.

"Medical Repatriation" means transportation to the Hospital or medical facility closest to the Insured's primary residence capable of providing continued, appropriate treatment.

"Medically Necessary" means that a treatment, service or supply is: (a) essential for diagnosis, treatment or care of the Accidental Injury for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is deemed necessary by the treating Physician; and (d) is ordered by a Physician and performed under the Physician's care, supervision or order.

"Physician" means a licensed health care provider of medical, surgical or dental services acting within the scope of the Physician's license and rendering care or treatment to the Insured that is appropriate for the Insured's medical condition(s) and locality where the services are provided. The treating Physician must not be related to the Insured.

"Policy" means this individual Policy document, the Schedule of Benefits, and any endorsements, riders or amendments that may attach during the period of coverage.

"Season Pass" means a ski or snowboard pass for multiple day usage throughout the duration of the ski or snowboard season, as defined by the Ski Resort.

"Ski Resort" means a designated area with facilities and marked trails for skiing and snowboarding.

"Starting Date" means the first date the Insured's Lift Ticket is valid during a Covered Activity.

"Unforeseen" means not anticipated or expected.

"We, Us, Our" means Starr Indemnity & Liability Company and its agents.
"You" and **"Your"** means the person who purchased this Policy and paid any required premium. You and Your includes the Insured.

SECTION II. GENERAL PROVISIONS

The following provisions apply to all coverages:

SUIT AGAINST US: No legal action related to a claim can be brought against Us:
(a) until 60 days after We receive Proof of Loss;
(b) unless there has been full compliance with all of the terms of this Policy; and
(c) more than 3 years after the time required for giving Proof of Loss.

MISREPRESENTATION AND FRAUD: All statements are considered to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements may not prevent a recovery under the Policy unless such statement is either:
(a) fraudulent;
(b) material either to the acceptance of the risk, or to the hazard assumed by Us; or
(c) We in good faith would either not have issued the Policy, or would not have issued a policy or contract in as large an amount, or at the same premium or rate, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to Us as required either by the application for the Policy or otherwise.

SUBROGATION: To the extent We pay for a loss suffered by the Insured, We will take over the rights and remedies You had relating to the loss. You must help Us to preserve Our rights against those responsible for the loss. This may involve signing any papers and taking any other steps We may reasonably require. If We take over Your rights, You must sign an appropriate subrogation form supplied by Us. Failure to comply with this provision could void or limit coverage. We will not retain any payments until You have been made whole with regard to any claim payable under the Policy.

CONFORMITY WITH LAW: Any part of the Policy that conflicts with the state law where the Insured resides is changed to meet the minimum requirements of that law.

PREMIUM: The required premium must be paid to Us, Our agent or to the Lift Ticket Broker prior to or on the Starting Date.

ENTIRE CONTRACT: This Policy and any attachments represent the entire contract between You and Us.

CANCELLATION BY THE INSURED: If You have purchased this Policy in conjunction with a Season Pass, You may cancel this Policy by giving Us written notice of Your request to cancel. Premiums will be refunded on a pro-rata basis within 45 days of the request for cancellation or the effective date of cancellation, whichever is greater. If You have purchased this Policy in conjunction with a single day Lift Ticket, You may cancel the Policy prior to the Effective Date and receive a full refund.

SECTION III. ELIGIBILITY AND PERIOD OF COVERAGE

ELIGIBILITY: An individual:
(a) for whom this insurance has been purchased; and
(b) for whom any required premium due has been paid; and
(c) who uses a pre-purchased single or multiple day Lift Ticket or who purchases and uses a single or multiple day Lift Ticket on the Starting Date,
is eligible to be insured under this Policy.

EFFECTIVE DATE AND POLICY TERM: The Effective Date of the Insured's Policy is the Starting Date indicated on the Insured's Lift Ticket.

When Coverage Begins:
Subject to payment of any premium due, coverage begins at:
(a) 12:01 a.m. on the Starting Date shown on the Insured's Lift Ticket if the Lift Ticket is pre-purchased; or
(b) the time and Starting Date of purchase shown on the Insured's Lift Ticket if You purchase the Insured's Lift Ticket on the same or first date it will be used.

When Coverage Ends:
Coverage is effective for the period between the Starting Date and the Expiration Date of the Insured's Lift Ticket. The Insured's coverage will end at 11:59 P.M. local time on the Expiration Date of the Insured's Lift Ticket.

SECTION IV. COVERAGES

Subject to the Maximum Benefit shown on the Schedule of Benefits, and subject to the terms, conditions, and exclusions in this Policy, We will provide benefits as described below.

A. Field Rescue

We will reimburse You for Field Rescue Expenses incurred if the Insured suffers an Accidental Injury during a Covered Activity that requires a Field Rescue at a Ski Resort. Benefits payable are subject to the Maximum Benefit shown on the Schedule of Benefits. In no event will We reimburse You for more than one (1) Field Rescue by appropriate authorities for any Covered Activity.

This benefit can only be activated when someone makes a formal report of the need for rescue to an agency or authority that can activate such a Field Rescue and the agency or authority is provided with specific details as to where the Insured might be located so that an official and organized Field Rescue can be activated. In the event the Field Rescue occurs after the Expiration Date, benefits will be provided subject to all terms and conditions of the Policy for Field Rescue if the Accidental Injury occurs prior to the Expiration Date.

B. Emergency Medical Evacuation

We will pay, subject to the limitations set out herein, for covered Emergency Medical Evacuation Expenses reasonably incurred if an Insured suffers an Accidental Injury that warrants the Insured's Emergency Medical Evacuation during a Covered Activity. Benefits payable are subject to the Maximum Benefit shown on the Schedule of Benefits.

If the Insured must be admitted to a Hospital due to a covered Accidental Injury, We will pay, subject to the limitations set out herein, for expenses:

(a) to return to the Insured's primary residence in the United States, with an attendant if necessary, any children, under the age of eighteen (18) who were accompanying the Insured when the Accidental Injury occurred and were left alone because of same. Our payment will not exceed the cost of a single one-way economy airfare ticket per person, less the value of applied credit from any unused return travel tickets;

(b) to bring one (1) person chosen by the Insured to and from the Hospital or other medical facility where the Insured is confined if alone, but not to exceed the cost of one round-trip economy airfare ticket and reasonable meals and accommodations.

Emergency Medical Evacuation to the nearest Hospital or other medical facility capable of providing appropriate treatment does not require Physician determination or coordination with Our designated Assistance Company. However, the necessity of transportation to a Hospital or medical facility other than the nearest facility, or transportation between Hospitals or other medical facilities, must be determined by a Physician, in coordination with Our designated Assistance Company. We or the Assistance Company must review and approve the necessity of the Emergency Medical Evacuation. However, if We or Our designated Assistance Company could not be contacted to

review and approve the Emergency Medical Evacuation, benefits are limited to the amount the Company would have paid had the Company or Our designated Assistance Company been contacted. Further, the escort of unattended minor children must be coordinated with Our designated Assistance Company. The Emergency Medical Evacuation and escort of unattended minor children must be coordinated through the most direct and economical conveyance and route possible, such as air, land ambulance or commercial airline carrier.

C. Medical Repatriation

In addition to the above covered expenses, if the local attending Physician and Our designated Assistance Company determine that a Medical Repatriation is medically appropriate, We or Our designated Assistance Company will arrange the Medical Repatriation. The Medical Repatriation must be coordinated through the most direct and economical conveyance and route possible, such as air, land ambulance or commercial airline carrier and approved, in writing, by Our designated Assistance Company.

All arrangements for Medical Repatriation must be made through Our designated Assistance Company. If We or Our designated Assistance Company could not be contacted to arrange for Medical Repatriation, benefits are limited to the amount the Company would have paid had the Company or Our designated Assistance Company been contacted.

D. Repatriation of Remains

If the Insured dies during a Covered Activity, We will pay the reasonable expenses incurred to transport the Insured's body to the Insured's primary residence, a funeral home selected by the Insured's family in the United States or to a burial location selected by the Insured's family in the country where the death occurs. Benefits payable are subject to the Maximum Benefit shown on the Schedule of Benefits.
Expenses that we will pay include the reasonable expenses incurred to prepare the Insured's remains and the transportation of such remains.

We will also pay the expenses incurred to return to the Insured's primary residence, any unattended children under the age of nineteen (19) who were accompanying the Insured on the Covered Activity at the time of the Insured's death, including the cost of an attendant, if needed. Our payment will not exceed the cost of a one-way economy airfare ticket per person, less the value of any applied credit from any unused return travel tickets.

All arrangements for repatriation of the Insured's remains and the escort of unattended minor children must be made through Our designated Assistance Company. If We or Our designated Assistance Company could not be contacted to arrange for Repatriation of Remains, benefits are limited to the amount the Company would have paid had the Company or Our designated Assistance Company been contacted.

SECTION V. CLAIMS PROCEDURES AND PAYMENT

All benefits will be paid in United States dollars. The following provisions apply to all benefits.

PAYMENT OF CLAIMS: We or Our authorized designee will pay undisputed portions of a claim (clean claim) within 30 days after receipt of acceptable written Proof of Loss. If specific additional information that is needed to adjudicate the claim, We will notify you of the additional information needed and will pay the claim not later than 15 calendar days after receipt of the additional specified information or within 30 days after receipt of the claim. If We do not pay the claim within the time period required, the claim is presumed to be a clean claim, interest at a rate of 15% accrues, and interest continues to accrue until the date the claim is paid.

All claims will be paid to You. All or a portion of all other benefits provided may, upon your written request, be paid directly to the provider of the service(s) or to third parties pursuant to a Qualified Domestic Relations Order. All benefits not paid to the provider will be paid to You. In the event You are incompetent or otherwise unable to give a valid release for the claim, We may make arrangements to pay claims to Your legal guardian, committee or other qualified representative. Any payment made in good faith will discharge Our liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by other insurance policies for the same loss.

NOTICE OF CLAIM: Written notice of claim must be given by the claimant (either You or someone acting for You) to Us or Our authorized designee within 20 days after a covered loss first begins or as soon as reasonably possible. Notice must include Your name, the Insured's name (if different), the Lift Ticket Broker's name (if any) and the Policy number. Notice must be sent to Our administrative office, at the following address: Starr Indemnity & Liability Claims Department 1601 Market Street, Suite 1800, Philadelphia, PA 19103 or to Our authorized designee. Notice given to us at the address noted above or to Our authorized agent with information sufficient to identify the Insured shall be considered notice to Us.

CLAIM FORMS: When We receive a notice of claim, We will send You the forms to be used in filing proof of claim. Paper forms will be provided if requested by the Insured. If We or Our designee do not send You these forms within 10 working days, You can meet the Proof of Loss requirement by sending Us or Our designee a written statement of the occurrence, nature and extent of the loss within the time allowed for filing Proof of Loss under this Policy.

PROOF OF LOSS: The claimant (either You or someone acting for You) must send Us or Our authorized designee Proof of Loss within 90 days after a covered loss occurs or as soon as reasonably possible. This must be a detailed, written statement. Failure to furnish proof within that time will not invalidate or reduce a claim if it was not reasonably possible to give proof within that time, provided the proof is furnished as soon as possible and in no event, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

OTHER INSURANCE WITH US: You may be covered under only one travel Policy with Us for each Covered Activity. If You are covered under more than one such Policy, You may select the coverage that is to remain in effect. In the event of death, the selection will be made by the beneficiary or estate. Premiums paid (less claims paid) will be refunded for the duplicate coverage that does not remain in effect.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to physically examine the Insured as often as is reasonably necessary while a claim is pending. We may choose the Physician. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

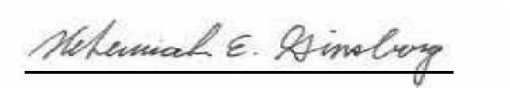
SECTION VI. GENERAL LIMITATIONS AND EXCLUSIONS

We will not pay for loss caused by or resulting from:

1. The Insured's Commission of, or attempt to commit, a criminal act;
2. Sickness;
3. the Insured's being intoxicated or under the influence of a narcotic unless administered on the advice of a Physician;
4. Any non-Emergency evacuation or medical repatriation;

5. Expenses caused by or as a result of the Insured's participation in Extreme Skiing;
6. Participation as a professional athlete; participation in non-professional, organized amateur or interscholastic athletics, sports competitions or events;
7. Pregnancy and childbirth of the Insured other than Unforeseen Complications of Pregnancy if hospitalized during a Covered Activity;
8. Suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane committed by the Insured;
9. The Insured's participation in civil disorder or riot;
10. Accidental Injury when traveling against the advice of a Physician;
11. Care or treatment that is not Medically Necessary;
12. Services not shown as covered;
13. Care or treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease Law; the 4800 Time Benefit plan or similar legislation;
14. Directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination; or
15. Expenses caused by or as a result of the Insured's injuries received at a Ski Resort outside the United States.

In Witness Whereof, We have caused this Policy to be executed and attested, but this Policy shall not be valid unless countersigned by Our duly authorized representative.



Nehemiah E. Ginsburg,
General Counsel and Secretary

Steve Blakey,
President and Chief Executive Officer

Notice of Protection Provided by the

Alaska Life and Health Insurance Guaranty Association

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 — 21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

EXCLUSIONS FROM COVERAGE

The association does not protect a person holding a policy if:

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state; or
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;

- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, $100,000 for coverages not defined as disability income, health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance and long-term care insurance;
- $500,000 for health benefit plans;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- with respect to a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000 in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased; or
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to any one contract holder or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by *the act:* for unallocated annuities that fund governmental retirement plans under

sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guaranty association should not be contacted regarding the financial information of an insurance company.

The association is not an agency of the State of Alaska nor are there any guarantees by the State of Alaska regarding the payment of claims by the association. The guaranty association is not your insurance company.

Alaska Life and Health Insurance Guaranty
Association P.O. Box 220207
Anchorage, Alaska 99522-0207
(907) 243-2311

Division of Insurance
550 West Seventh Avenue, Suite
1560 Anchorage, Alaska 99501-3567
(907) 269-7900