Exhibit H

**IN THE CHANCERY COURT OF ROBERTSON COUNTY, TENNESSEE**
**FOR THE NINETEENTH JUDICIAL DISTRICT AT SPRINGFIELD**

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AMERICAN TRADE ASSOCIATION, INC.,
by and on behalf of its members,

Plaintiff,

v.

WILLIAM M. WORTHY II,
SOUTH EAST INSURANCE ADVISORS, LLC,
and NATIONWIDE ADMINISTRATORS, LLC,

Defendants.

Docket No. 21229
**JURY TRIAL DEMANDED**

FILED
CLERK & MASTER ROBERTSON CO, TN
OCT - 1 2010
AT 11:30 O'CLOCK A M
KENNETH HUDGENS
BY KC

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**COMPLAINT FOR FRAUD, CONVERSION, ACTION QUANTUM MERUIT, COMPENSATORY AND PUNITIVE DAMAGES AND FOR ATTACHMENT**

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TO THE CHANCELLORS OF THE CHANCERY COURT OF ROBERTSON COUNTY, TENNESSEE:

COMES now the Plaintiff, American Trade Association, Inc. ("ATA"), by its undersigned counsel and herein sues the Defendants William M. Worthy, II, South East Insurance Advisors, LLC, and Nationwide Administrators, LLC for **FRAUD, CONVERSION, ACTION QUANTUM MERUIT, COMPENSATORY AND PUNITIVE DAMAGES** extending from Defendants' intentionally false, fraudulent, scheme to defraud by the sale of nonexistent insurance coverage perpetuated by the blatant, intentional and malicious and fraudulent creation, fabrication and circulation of falsified documents, letters, correspondence and purported insurance finders and perceived insurance policies designed to intentionally defraud the Plaintiff, its members and to cause through false and fraudulent means to obtain personal financial information from the ATA's members which is presently being used, through

yet another false and fraudulent scheme to defraud its members through the alleged sale of insurance, and states as follows:

1. In this action, ATA seeks to recover damages it has sustained as a result of the intentionally false and fraudulent misrepresentations of defendants in connection with their purported placement of insurance coverage for ATA with Beema-Pakistan Co. Ltd ("Beema") and its alleged affiliate Serve America Assurance Ltd. ("SAA"). ATA further seeks an order restraining the alleged trust accounts into which its premium funds were deposited by defendants to prevent loss of ATA's premium and so it can access that money to pay claims in light of defendants' refusal to do so, allegedly on behalf of Beema/SAA.

## PARTIES

2. ATA is a corporation formed under the laws of Indiana, and has its principal place of business in Robertson County, Tennessee and/or resulted from agreements formed in or representations made in Robertson County, Tennessee.

3. Upon information and belief, William M. Worthy II ("Worthy") is an individual residing in South Carolina.

4. Upon Information and belief, SouthEast Insurance Advisors, LLC ("SEIA") is a Limited Liability Company conducting business in Isle of Palms, South Carolina.

5. Upon information and belief, Nationwide Administrators, LLC ("Nationwide") is a Limited Liability Company conducting business in Blythwood, South Carolina.

6. Upon information and belief, Worthy personally directs and controls both SEIA

and Nationwide for his personal gain and profit, and is a member, officer, director, shareholder, employee and/or agent of both SEIA and Nationwide.

## JURISDICTION AND VENUE

7. Jurisdiction and venue in this case are proper because the acts complained of occurred in Robertson County, Tennessee.

## BACKGROUND

8. ATA is a corporation formed under the laws of Indiana, and has its principal place of business in Tennessee.

9. ATA is a trade association that offers certain benefits to its members, including limited healthcare benefits. These healthcare benefits are an important service to ATA's members that would otherwise not be able to afford healthcare in this time of spiraling healthcare costs and increasingly limited availability of employer-provided health insurance.

10. ATA provides these limited medical benefits to its members by arranging for a group health insurance policy to be issued to ATA as the named insured, and the health insurer then issues certificates of coverage to ATA's members. Claims for medical benefits made by members are handled by SDS as third party administrator.

11. The association medical benefits business has been tainted in recent years by a collection of bad actors, including Worthy and the other Defendants, that have engaged in unscrupulous business practices, and have been alleged to have harmed the general public. ATA has, unfortunately, been lumped in with these bad actors, and has had difficulty in retaining its

group health insurance policy as a result of Defendant Worthy who perpetuated this fraud on not only the ATA but on its members through the sale of false and fraudulent insurance coverage, obtaining personal and financial information from the members which is now being used to further perpetuate fraud through the sale of yet additional false and fraudulent insurance.

12. In early 2008, William M. Worthy, II ("Worthy"), who is not an insurance broker, who is not a licensed agent or producer but who represented himself to be the authorized representative of Beema based in South Carolina, approached SDS to secure insurance for ATA through an insurance carrier that would meet the requirements for providing insurance to ATA's members.

13. Worthy, according to his statements and assertions, is the principal of SouthEast Insurance Advisors, LLC ("SEIA"). In February 2008, Worthy advised SDS in an email that Beema-Pakistan Company, Limited ("Beema"), an insurer based in Pakistan, would agree to provide a group heath insurance policy to ATA. A true and correct copy of that email is attached hereto as Exhibit 1.

14. Worthy followed up that email with a March 10, 2008 letter, representing that he had authority of Beema, and a Bermuda captive it owned called Serve America Assurance Ltd. ("SAA"), as its United States representative, and appointing SDS as third party administrator to handle the ATA claims, bill and collect premium, and remit net premium to SEIA's trustee, Ron Ehli of EZ-Pay Financial Services. SDS was to forward claims to be paid, and the funds to pay claims were to be wired to SDS's claims account. The letter confirmed that the ATA plan was

fully insured by Beema and SAA. A true and correct copy of that letter is attached hereto as Exhibit 2.

15. Worthy further confirmed the insurance arrangement for ATA in an email dated March 16, 2008 to SDS's counsel. A true and correct copy of that email is attached hereto as Exhibit 3.

16. In a letter purportedly sent on behalf of Beema, dated March 18, 2008, Colin Youell, who represented himself as a director of Beema, purported to provide binding authority to SEIA and Worthy. A true and correct copy of that letter is attached hereto as Exhibit 4.

17. Beema later confirmed in an undated letter that Beema's offshore captive, SAA, issued a master policy for mini-med indemnity to ATA, and SDS was the administrator of the plan. A true and correct copy of that letter is attached hereto as Exhibit 5. A true and correct copy of the master policy issued to ATA by SAA and signed by Carl Youell as its President is attached hereto as Exhibit 6.

18. SDS, in reliance on the information and documentation provided by Beema, as administrator on behalf of ATA and Beema, issued certificates to ATA members, and forwarded the net premium to the account designated by SEIA at EZ-Pay Financial Services. SDS administered the claims of ATA members as third party administrator, and submitted those claims for payment to SEIA's designated trustee, EZ-Pay Financial Services.

19. In October 2008, Worthy purportedly, on behalf of Beema, directed SDS to utilize a new escrow account for Beema in the name of Nationwide Adminstrators, LLC, held at First

Citizens Bank in Blythwood, South Carolina. A true and correct copy of the October 3, 2008, email is attached hereto as Exhibit 7.

20. ATA and SDS first became aware that the insurance for ATA members through Beema and SAA might be problematic in 2009, when various state insurance regulators began conducting detailed inquiries into the fraudulent activities of other associations that were engaged in fax-blasting consumers in various states.

21. In connection with the various states' inquiries to SDS and ATA, Beema and SAA provided correspondence purportedly confirming that ATA had insurance through Beema and SAA. A true and correct copy of an email dated September 3, 2009 is attached hereto as Exhibit 8.

22. However, despite repeated assurances from Worthy that a written statement from Beema and SAA would be forthcoming and would be sent directly to various state insurance departments, the one letter that was allegedly produced by Beema and sent to SDS in fact stated that Beema has never issued a policy to an entity in the United States, and that Beema does not own any subsidiary, company or other legal entity outside Pakistan. A true and correct copy of that undated letter is attached hereto as Exhibit 9.

23. As a result of the misrepresentations made by Worthy and SEIA, which SDS and ATA relied on to their detriment, SDS notified Worthy on October 21, 2009 that it would make no further payments to Beema/SAA. A true and correct copy of that emailed letter is attached hereto as Exhibit 10.

24. Undeterred by SDS's position, and in an apparent effort to keep his fraudulent gravy train flowing, Worthy wrote to SDS on November 17, 2009, advising that the policies underwritten by SAA had been assumed by Ittefaq General Insurance Company, and that he was negotiating with a fronting insurer to act as the insurer of the policies, which Ittefaq had already agreed to reinsure. A true and correct copy of the November 17, 2009 email from Worthy is attached hereto as Exhibit 11.

25. Worthy claimed to be an authorized agent for an insurer, and therefore cannot retain ATA's premium funds. He was required to hold the premium funds in trust for ATA's insurer, and forward the premium to ATA's insurer.

26. However, on information an belief, Worthy did not secure an insurer for ATA, and did not forward ATA's premium funds to any insurer.

27. On information and belief, Worthy has improperly retained ATA's premium funds.

28. Despite having received premium funds, which were required to be held in trust for ATA's insurers, from SDS on behalf of ATA and its members, Worthy, SEIA, Nationwide Administrators, LLC, the claimed trustees, agents and representatives of Beema and SAA, have refused to pay claims duly submitted by SDS, which is causing continued damage to ATA and SDS, and the claims submitted by ATA members are being paid by SDS.

29. Absent injunctive relief, ATA faces the prospect of substantial irreparable harm. Premium funds have been forwarded to Worthy, SEIA, and Nationwide Administrators LLC to

secure coverage, and are required to be held in trust until forwarded to the insurer.

30. It is apparent that ATA's premium funds have not been forwarded, but have instead been retained by defendants. To avoid irreparable harm that might result to ATA if its premium funds are not available to pay claims, the premium funds must be immediately restrained to prevent their dissipation by Worthy and his collaborators in the fraud against ATA and SDS.

31. Such funds must be placed in an account under supervision of the court to avoid harm to ATA members.

**FRAUD**

32. Plaintiff repeats, realleges and incorporates herein by reference all prior allegations.

33. Worthy and SEIA represented to ATA that they were the authorized agents and representatives of Beema and SAA, and, as such, had the authority to bind Beema and SAA to insurance policies.

34. That representation was false when made, and known to be false by Worthy and SEIA.

35. In reliance on Worthy and SEIA's false representations, ATA paid insurance premiums to Worthy and SEIA, or at their direction, into trust accounts that were represented to be designated for payment of ATA's claims by Beema or SAA.

36. Beema and SAA, through Worthy and SEIA, have failed and refused to honor ATA's claims despite being paid premium by ATA for insurance coverage, which has caused ATA and its administrator SDS to have to pay the claims out of their own funds.

37. ATA has been damaged by Worthy and SEIA's actions in an amount to be determined at trial, but in no event less than $2 million.

## CONVERSION

38. Plaintiff repeats, realleges and incorporates herein by reference all prior Allegations as if stated verbatim.

39. Defendants have assumed and exercised rights of ownership over premium funds that were paid to them on behalf of ATA for purposes of securing insurance coverage from Beema and SAA.

40. ATA has not authorized the assumption and exercise of rights of ownership of insurance premiums by defendants.

41. ATA has an immediate, superior and lawful right to this property.

42. All necessary demands for return of the aforementioned property have been made and Defendants failed and refused to deliver and/or return this property to ATA.

43. Defendants acted willfully and intentionally and with knowledge of ATA's rights in the property.

44. As a direct and proximate result of the foregoing, ATA has suffered damages and is entitled to recover from the Defendants the loss of property, interest, loss of profits, and other consequential and incidental damages.

## UNJUST ENRICHMENT

45. Plaintiff repeats, realleges and incorporates herein by reference all prior allegations.

46. Since approximately February 2008, Defendants Worthy and SEIA acted as ATA's agent in securing insurance coverage for ATA's members from Beema and SAA, while acting as the purported exclusive agent of Beema and SAA.

47. Upon information and belief, Defendants have collected from ATA, and failed and refused to remit, or otherwise make available more than [$2 million] in premium collected from ATA designated for the payment of claims from ATA members, in violation of its role as agent under both South Carolina common and statutory law.

48. Defendant Worthy was complicit in and directed others at Defendant SEIA and Nationwide not to pay ATA's claims in breach of trust and their fiduciary duties.

49. By collecting, retaining and failing to pay ATA's member's claims funds that the Defendants collected from ATA, the Defendants have received and realized a substantial benefit in the use of money.

50. It is unjust under South Carolina common and statutory law for the Defendants to retain the benefit of the use of ATA's premium, all without the actual authority of Beema and SAA to do so, and Defendants are not entitled to be wrongfully enriched at ATA's expense.

51. ATA is entitled to restitution of its improperly retained premium.

## ACCOUNTING

52. Plaintiff repeats, realleges and incorporates herein by reference all prior allegations as if stated verbatim.

53. Despite numerous demands made by ATA, Defendants continue to fail and refuse to account in full for premium and other trust funds that the Defendants collected from ATA.

54. An accounting is necessary to: (a) determine (i) how much premium was collected by the Defendants, (ii) what became of the premium paid by ATA once it entered the hands of Defendants, (iii) who received ATA's premium; and (b) award ATA all premium wrongfully collected from ATA and retained by Defendants, together with all losses, costs, expenses, indemnities and the reasonable attorney's fees of ATA in this action.

## TENNESSEE CONSUMER PROTECTION ACT

55. The Plaintiff reincorporates Paragraph 1 through 54 as if stated herein verbatim and herein sues the Defendants for violation for the Tennessee Consumer Protection Act (i.e., T.C.A. §47-18-101 et seq.)

56. As such, it is alleged that the Tennessee Consumer Protection Act (the "Act") was enacted:

"(ii) To protect consumers and legitimate business enterprises from those who engage in unfair or deceptive acts or practices and the conduct of any trade or commerce in part or wholly within this State."

The Act further provides at T.C.A. §47-18-104(b)(27):

"(b) Without limiting the scope of subsection (a), the following unfair or deceptive acts or practices affecting the conduct of any trade or commerce are declared to be unlawful and in violation of this part:

(27) engaging in any other act or practice which is deceptive to the consumer or to any other person."

57. It is further specifically averred pursuant to T.C.A. §47-18-109(3) that this private causes of action also provides for the award of treble damages where the Court finds the use of or employment of the unfair or deceptive act or practice was a willful or knowing violation of this part.

58. It is further specifically averred pursuant to T.C.A. 47-18 -109(e)(1) that this private cause of action also provides for the award of reasonable attorneys' and costs upon a finding that the Act has been violated.

59. The Act further provides at T.C.A. §47-18-109(a)(1) as follows:

"(a)(1) Any person or who suffers an ascertainable loss of money or property, real, personal or mixed, or any other article, commodity, or thing of value wherever situated, as a result of the use or employment by another person of an unfair or deceptive act or practice is declared to be unlawful by this part, and may bring in action individually to recover actual damages."

60. Both natural persons and business and entities are specifically included within the Act's definition of "person" which is defined at T.C.A. § 47-18-103(9) as follows:

"Person" means a natural person, individual, governmental agency, partnership, corporation, trust, estate, incorporated or unincorporated association and any other legal or commercial entity however organized."

## INJUNCTIVE RELIEF

61. Plaintiff repeats, realleges and incorporates herein by reference all prior allegations as if stated verbatim.

62. Defendants have assumed and exercised control over at least [$2,000,000] in ATA premium funds that Defendants collected from ATA.

63. All premiums collected from ATA were required to be held in trust. Absent injunctive relief from the Court, ATA faces a substantial likelihood of irreparable harm in Defendants' dissipation and transfer of ATA's property.

64. The harm to Defendants from an injunction is minimal as the premium can be deposited into a court-approved escrow or trust account.

65. ATA has an overwhelming likelihood of success on the merits of its claims to the ATA premium funds that Defendants collected and were supposed to hold in trust.

66. The public interest, as expressed in the Tennessee statutes, weighs in favor of equitable relief to prevent agents from absconding with premiums collected from policyholders.

67. ATA is entitled to a temporary restraining order and preliminary injunction requiring Defendants to cease all further transfers of ATA's premium and to pay all such premium into a court-approved escrow or trust fund.

68. ATA is further entitled to a prejudgment attachment over the funds held in the trust account that Defendants directed ATA to deposit its premium funds into, located at First Citizens Bank in Blythewood, South Carolina, under T.C.A. § 29-6-101.

WHEREFORE, the Plaintiff respectfully requests that this Court:

1. Enter judgment in favor of the Plaintiff and against Defendants for all actual, consequential, and incidental damages suffered by the Plaintiff as a result of Defendants' breaches of contract, breaches of their fiduciary duties owed to ATA and for their willful and intentional conversion of ATA's premium and other trust funds.

2. Award the Plaintiff punitive damages in an amount sufficient to punish Defendants for their conduct, which is willful, wanton, or in reckless disregard of Plaintiff's rights.

3. Enter a Temporary Restraining Order and Preliminary Injunction prohibiting Defendants from making any further transfers of ATA's premium without Court permission, and ordering Defendants to pay all premium not remitted to ATA into the Court.

4. Enter a prejudgment attachment over the account held at First Citizen's Bank in Blythewood, South Carolina into which ATA was directed to deposit its premium funds.

5. Award to Plaintiff interest, attorney's fees and costs to the fullest extent allowable under the law.

6. Award to Plaintiff such other and further relief as the Court deems just and proper.

Respectfully submitted,

EVANS PETREE BOGATIN PC
1661 International Place Dr., Suite 300
Memphis, TN 38120
(901) 767-1234 (Phone)
(901) 374-7510 (Fax)

William L. Hendricks /by ccc cy permission
WILLIAM L. HENDRICKS, JR. (#11527)

Clayton C. Chandler
CLAYTON C. CHANDLER (#027143)

STATE OF TENNESSEE
ROBERTSON COUNTY

I, Kenneth Hudgens, Clerk & Master of the Chancery Court of said County, do hereby certify that the foregoing instrument contains a true and complete copy of Complaint with attached Exhibits 1-11 as same appears of record or on the file in Book ____ Page ____ of the records of Robertson County, Tennessee
Given under my hand and seal this 3 day of March 2010

KENNETH HUDGENS, Clerk & Master

By K. Chowning DC



*Exhibit 9 not attached to Original Complaint at time of Filing - KC

# Exhibit 1

## Bart Posey

**From:** wworthy35@comcast.net
**Sent:** Wednesday, February 13, 2008 9:12 AM
**To:** Bart Posey; Angie Posey
**Subject:** Accident Benefit

Bart,

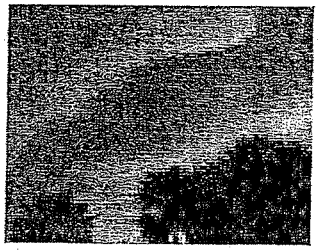
I just received confirmation verbally that Beema will write the accident benefit for 6 dollars pmpm. I will get the confirmation in writing.

Please confirm how many lives will come in February.

Thanks,

William
Sent from my Verizon Wireless BlackBerry

# Exhibit 2



SouthEast Insurance Advisors, LLC
Post Office Box 462
Isle of Palms, South Carolina 29451

3-10-2008

Mr. Bart Posey
Smart Data Solutions, LLC
4676 Highway 41 North
Springfield, TN 37172

Re: Mini-Med Plans, Per Occurrence Plans and Cat Plan

Dear Bart:

As per the approval from Beema Insurance Co. LTD and Serve America Assurance And under my authority as the United States Representative for the above entities, your firm is appointed as the approved Third Party Administrator for these plans effective 1-1-08. SDS, LLC agrees to maintain proper licensing and E&O Coverage for its officers and employees as part of this agreement.

You are authorized to bill and collect premium and remit net insurance premium to our trustee, Ron Ehli, of EZ-Pay Financial Services. You are authorized to pay claims for the mini-med plans, the high excess Cat plans, the per occurrence plans and the accident/medical plan. Twice monthly you will forward a list of claims to be paid along with the dollar amount of the benefits. The funds will be wired directly to your claims account by our trustee and you will release the checks upon receipt of funds.

This agreement will be for a term of 2 years from the above date and shall automatically renew in two year increments unless cancelled in writing by either

party. Either party may cancel the agreement for cause in writing with a minimum 60 day termination date. SDS, LLC agrees to open disclosure of its books regarding these plans to Beema Insurance Company LTD or its legal representative at any time with proper notice. Beema Insurance Co LTD agrees to meet any call for claims cash when proper documentation is sent to substantiate claims being due and payable. It is understood that the benefits of the above listed plans are 100% insured and underwritten by and for Beema Insurance Co. LTD and its off-shore captive Serve America Assurance.

Best Regards,

William Worthy
SouthEast Insurance Advisors LTD

FILED
CLERK & MASTER ROBERTSON CO, TN

MAR 0 1 2019

AT 11:32 O'CLOCK A M
KENNETH HUDGENS

BY _____

Exhibit 3

## Bart Posey

**From:** wworthy35@comcast.net
**Sent:** Sunday, March 16, 2008 8:45 PM
**To:** bhendricks@glankler.com
**Cc:** Bart Posey; Rick Bachman
**Subject:** Letter

Dear Bill,

I hope you had a great weekend! I am in receipt of your letter dated March 14, 2008, and I would like to address your issues.

The Beema representatives have been working on their own Government issues this past week and have been unable to direct me to the their legal council in the states. However, on behalf of the entire program for SouthEast Insurance Advisors and American Trade Association/SDS, Beema has established an offshore captive called Serve America Assurance, Ltd. to take the entire risk for this program. Beema has also secured E &O coverage for any agents that will write business through the Captive. All policies from the Captive will be issued directly to American Trade Association, LLC.

As you may or may not be aware of, Beema has issued a letter authorizing SDS to process all claims for the products issued to American Trade Association, LLC. The premium account has been established through EZPay Fincancial Services, Inc. This is an established relationship that has been in effect for many years. Currently there are two trust accounts labeled Beema High Excess Plan and Beema Mini Medical. Once the premium is received into the master premium account, it is transferred into the appropriate accounts. Soon there will be separate accounts for the Per Occurrence Plan and the Accident Plan, all of which will continue under EZPay Financial Services, Inc.

The process of claims payment is real simply, SDS will process a weekly check cycle. They will submit the amount to EZPay and they will wire the money into the SDS claims account. Although this is SDS's first TPA experience, it is very uncommon for any TPA to retain any premiums on behalf of the carrier. Beema will NOT be setting up any other arrangements to pay claims other than what has been illustrated.

I trust you will find this letter satisfactory. If you have any questions, I will be flying to Nashville in the morning and I will be with Bart and Rick in the afternoon.

Sincerely,

William Worthy

**Exhibit 4**

REAL INSURANCE

412 - 427, Muhammadi House,I. I. Chundrigar Road, P.O. Box 5626, Karachi - 74000 Pakistan
PABX : 92 - 21-2429530 -33 Fax: 92-21-2429534
email: info@beemapakistan.com - beemapakistan@yahoo.com
web: www.beemapakistan.com

بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Tuesday, March 18, 2008

The Directors of SouthEast Insurance Advisors LLC
Via Email address

RE AUTHORIZATION TO BIND/COLLECT PREMIUM FOR THE AFFINITY MINI MED PLANS 100-1000

Dear William

We thank you, for the presentation and opportunity, to provide coverage under any of the club Mini Medical plans 100 to 1000.
You are now hereby authorized to attach coverage to us, this authority, extends to allow you, to Bind and collect premium as per the rates quoted in the documents submitted to us.

We backdate this facility to the first of Feb 2008 subject to no known or reported losses.

We do require you to set up separate bank accounts forth-with.

We shall write to you further setting out matters of a procedural nature that we need to have you adhere to.

We look forward to your confirmation we are now to proceed, in which case we will prepare out cover note setting out the terms and conditions agreed between us.

Best and kind regards

Director

FILED
CLERK & MASTER ROBERTSON CO, TN
MAR 0 1 2010
AT 11:30 O'CLOCK A M
KENNETH HUDGENS
BY KC

**Exhibit 5**

412 - 427, Muhammadi House,I. I. Chundrigar Road, P.O. Box 5626, Karachi - 74000 Pakistan
PABX : 92 - 21-2429530 -33 Fax: 92-21-2429534
email: info@beemapakistan.com - beemapakistan@yahoo.com
web: www.beemapakistan.com

بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

To Whom it may concern,

This letter will confirm our structure of our program. Serve America Assurance, Ltd., an offshore captive, owned by Beema-Pakistan Company Limited, has issued a Master Policy to American Trade Association, Inc. to insure all of its members through our Mini Medical Indemnity Policies. The plans are marketed to the association members and are administered through Smart Data Solutions, LLC.

The tax ID number assigned to Serve America Assurance, LTD is 26-4196209.

Yours truly,

Saifuddin Ahmed
Chief Underwriter

Exhibit 6

# SERVE AMERICA ASSURANCE

Administrative Office
SDS, LLC
4676 Highway 41 North
Springfield, TN 37172

## MASTER POLICY OF INSURANCE

This is your Master Policy of Insurance for your Association. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and US. The Policyholder is shown on the Schedule.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payments are determined by all the terms, conditions and limitations of the Policy. The Policy may be amended from time to time without your Consent or notice to you. Any such amendment will not affect a claim starting before the Amendment takes effect.

The Policy has been issued and delivered to the Policyholder. The Policy is held by the Policyholder. As a participant of the Policy, you may inspect it at any time during business hours at the office of the Policyholder.

President

HIGH DEDUCTIBLE MAJOR MEDICAL EXCESS COVERAGE

NON-PARTICIPATING

# TABLE OF CONTENTS

# GENERAL DEFINITIONS

Accident: A sudden, unforeseen event which results in injury.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory authority to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the necessary care. Air ambulance charges are payable only for the transportation from the site of an emergency to the nearest available Hospital that is equipped to treat the condition instead of local ground Ambulance service.

Class: A category of persons based on student status, job, salary or some other condition of employment or membership. Eligible classes are shown on the Schedule.

Company: SERVE AMERICA ASSURANCE. Also hereinafter referred to as We, Us, and Our.

Complications of Pregnancy: A condition which 1) When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: a) acute nephritis; b) nephrosis; c) cardiac decomposition; d) missed abortion; e) eclampsia; f) puerperal infection; g) R.H. Factor problems; h) severe loss of blood requiring transfusion; i) and other similar medical and surgical conditions of comparable severity related to pregnancy; or when pregnancy is terminated: a) non-elective caesarean section; b) ectopic pregnancy that is terminated; and c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of pregnancy will not include: a) false labor; b) occasional spotting; c) Doctor prescribed rest during the period of pregnancy; d) morning sickness; e) preclampsia; and f) Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to the child or mother.

Covered Charge: The reasonable and customary charge incurred for a service or supply which is performed or given under the direction of a Doctor for Medically Necessary treatment of a sickness or injury which is covered by the Policy and incurred by a Covered Person. That portion of any charge which is in excess of the Reasonable and Customary charge for a particular service or supply in the area where it is incurred is not a covered charge. A covered charge is considered incurred on the date the treatment or service rendered or the supply is furnished.

Covered Person: A Person: a) who is eligible for coverage as the insured or as a Dependent; b) Who has been accepted for coverage or has been automatically added; c) who has paid the required premium; and d) whose coverage has become effective and is not terminated.

Dependent: A person who is the insured's: a) Legally married spouse residing with the insured; b) child who is dependent upon the insured for support and maintenance and is under the age of nineteen (19); c) Child who is dependent upon the insured for support and maintenance, is between 19 and 25 years of age and is attending school full-time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the insured's unmarried: a)natural child; b) stepchild; A stepchild is a dependent on the date the insured marries the child's parent; c) adopted child, including a child places with the insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

In the event both parents of a dependent child are insured persons, such child is considered a dependent of either parent. The child may not be considered a dependent of both parents.

Doctor: A legally qualified person licensed in the healing arts and practicing within scope of his or her license and is not a direct Family Member.

Emergency: A sickness or injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonable be expected to result in any of the following: a) the patient's life or health would be in serious jeopardy; b) bodily functions would be seriously impaired; or c) a body organ would be seriously damaged.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if: reliable evidence shows that's the prevailing opinion among experts regarding the drug, device or medical care and treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and article sin authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Family member: A person who is related to the Covered Person, in any of the following ways; spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother or father-in-law, parent (includes stepparent), brother, sister (includes stepsister or brother), or child (includes legally adopted or step-child). A Family Member includes an individual who normally lives in the Covered Person's household.

Hospital: An Institution licensed, accredited or certified by the State which: a) is accredited by the Joint Commission of Accreditation of Healthcare Organizations; b) Provides 24-hour nursing service by licensed registered nurses, (RN); c) mainly provides diagnostic and therapeutic care under the supervision of Doctors while hospital confined; and d) maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged, a nursing home, or an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse, except as specifically provided in the Policy
Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 24 consecutive hours for which a room and board charge is made by reason of sickness or injury for which benefits are payable.

Injury: Bodily injury due to an accident which: a) results solely, directly and independently of disease or bodily infirmity; b) Occurs after the Covered Person's effective date of coverage; and c) Occurs while coverage is in force.

All injuries sustained in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of a sickness or injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it; a) Is experiment/investigational or for research purposes; b) is provided solely for educational purposes or the convenience of the patient, the patients family, Doctor, Hospital or any other provider; c) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where on going treatment is merely for maintenance or preventative care; d) could have been omitted without adversely affecting the patient's condition or the quality of medical care; e) involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); f) involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues manual; or g) can be safely provided to the patient in a more cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is medically necessary.

Mental or Nervous Disorder: Nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a covered person.

Policyholder: The entity shown as the Policyholder on the Schedule

Pre-Existing Condition: A Sickness or injury for which medical care, treatment, diagnosis or advice was received or recommended within the 12 month period immediately prior to the Covered Person's effective date of coverage under the Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months prior to the covered person's effective date of coverage under this Policy. Treatment includes taking of Prescriptions Medicines or drugs.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal Law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current AMA policies.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: a) the actual amount charged by the provider; b) the negotiated rate, if any; or c) the charge which would have been make by the provider of medical services for a comparable service or supply make by other providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary Charges, Fees or Expenses will be based on statistically valid data for the most current medical and surgical codes and nomenclature and will be updated at least every six months.

In determining whether a charge is reasonable, We may consider such factors as We, in the reasonable exercise of Our discretion, determine are appropriate, including but not limited to: a) the complexity of the service or supply involved; b) the degree of professional skill, experience and training required for a Doctor to be able to perform the procedure or service; c) the severity or nature of the Injury or Sickness being treated; d) the provider's adherence or failure to adhere to charging and billing practices generally accepted by the established United States medial society as determined by Us; or e) the cost to the provider of providing the service or supplies, or performing the procedure.

Sickness: Illness and disease which begin after the effective date of a Covered Person's coverage.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of filling and caps and is not carious, abscessed, or defective.

You, Your and Yours: The insured shown in the Schedule

We, Ours, and Us: The SERVE AMERICA ASSURANCE

## ADDITIONAL DEFINITIONS

Calendar Year: The period of time beginning January 1 and ending on December 31 of the same year. The first Calendar year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31st after a Covered Person's effective date of coverage.

Durable Medical Equipment: A device which: a)is primarily and customarily used for medical purposes, is specifically equipped with features and functions that are generally not required in the absence of sickness or injury and is able to withstand repeated use; b) is used exclusively by the patient; c) is routinely used in a Hospital but can be used effectively in a non-medical facility; d) can be expected to make a meaningful contribution tot eh patient's sickness or injury; and e) is prescribed by a Doctor and the device is medically necessary for rehabilitation.

Durable medical equipment does not include: a) comfort and convenience items; b) equipment that can be used by Family members other than the covered person; c) health exercise equipment; and d) equipment that may increase the value of the insured's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to, modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Home Health Care: The provision of health service in the patient's residence under a plan of care established, approved in writing by the attending Doctor and certified by the attending Doctor as an alternative to Hospital Confinement or confinement in a skilled nursing facility. Each visit by a representative of a Home Health Agency is considered as one Home Health Care visit. Four hours of home health aide service is considered as one Home Health Care Visit. If service extends beyond four hours, each four hour or portion of that period is considered as one Home Health Care visit.

Home Health Care includes: part time nursing care by or supervised by a licensed registered nurse part-time home health care aid services which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; and medical supplies. Orthopedic appliances; durable medical equipment; prescription drugs and insulin, but only to the extent that such charges would have been considered covered expenses had the patient required Hospital Confinement or confinement in a skilled nursing facility.

Home Health Agency: An Agency or organizational that: a) Specializes in giving nursing care or therapeutic services in the home; b) is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVIII of the Social Security Act of 1965, as amended; c) is operating within the scope of its license or certification; and d) maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even is the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Agency.

Hospice: means an agency which provides a coordinated, interdisciplinary program for meeting the physical, psychological and social needs of a dying person and their families. A Hospice must: a) Be certified as a Hospice care program by Medicare; b) meet the standards of the National Hospice Organization, the Joint Commission of Accreditation of Hospitals, or similar standards; c) operate primary for Hospice Care; and d) provide full time supervision of at least one Doctor.

Hospice Care: Services provided by a Hospice providing care to an individual for whom a certified medical prognosis has been make indicating life expectancy of 6 months or less and who has elected to receive such care in lieu of other medical benefits provided herein.

Intensive Care: A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the surgical recovery room and from other rooms, beds and wards customarily used for patient care. Additionally they must be staffed and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusive to the intensive care unit.

Intensive Care Unit does not mean any of these step-down units: Progressive care intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for intensive care.

Medicaid: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Medicare: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Nurse: A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who: a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and b) provides medical services which are within the scope of the nurse's license or certificate.

Physiotherapy: Any form of the following administered by a Doctor: a) physical or mechanical therapy; b) diathermy; c) ultra-sound therapy; d) heat treatment in any form; or e) manipulation or massage.

Skilled Nursing Care: A place that meets all of the following requirements: a) Is legally operated as a Skilled Nursing Facility; b) primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Doctor; c) provides continuous 24-hour a day nursing service by or under the supervision of a licensed nurse; and d) maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval upon request.

Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for rest, residential, retirement, or custodial care.

# CONDITIONS OF INSURANCE

## *ELIGIBILITY*

**Insured:** You are eligible for coverage when you complete a valid application, meeting Our underwriting standards for coverage and pay the initial premium.

**Dependent Spouse:** Your dependent lawful spouse is eligible for coverage the later of: a) the date You become eligible for insurance; or b) The date of the marriage to You.

Your dependent spouse must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

**Dependent Child:** A dependent child is eligible for coverage on the later of: a) the day You become eligible for insurance; or b) the date you acquire the dependent child.

A dependent child is deemed to be acquired as follows: a) Natural birth: On date of birth; b) Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement; or c) Stepchild: On the date of Your marriage to the child's parent.

Your dependent child (ren) must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

## *EFFECTIVE DATE*

**Insured and Dependents, except Dependents Acquired After the Effective Date: Coverage is effective as stated on the schedule.**

Dependents Acquired After Effective Date

**Newborn Children:** Your newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However you must notify Us in writing within 31 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child to continue beyond such 31 day period.

**Adopted Child:** Coverage for an adopted child is effective upon the date of placement for adoption. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, You must notify Us in writing within the 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child to continue beyond such 31 day period.

"Placement for Adoption" means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with You terminates upon the termination of the legal obligations.

**Dependent Spouse:** A dependent spouse is eligible for coverage on the date of lawful marriage to You. Application and premium must be received within 31 days of the marriage. Coverage will become effective following Our acceptance of the spouse's application and payment of the required premium.

**Enrollment under Court Orders:** If pursuant to a court order which meets the specifications of 20-7-1200 of the statutes, You are required to provide health coverage for a child and You are eligible for dependent coverage, we shall: a) permit you to enroll a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions; b) if you are enrolled but fail to make application to

obtain coverage for the child, enroll the child under the Policy upon applications of: 1) the child's other parent; 2) the state agency administering the Medicaid program; or 3) the state agency administering 42 U.S.C. 651 to 699, the child support enforcement program; and c) continue coverage of the child unless We are provided satisfactory written evidence that: 1) Court order is no longer in effect; 2) Child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or 3) the Policyholder has eliminated family health coverage for all its members.

## *TERMINATION*

**Covered Person:** Coverage with respect to a covered person will terminate at 12:01 A.M. standard time at your residence on the earliest of: a) the date the Policy terminates; b) the date coverage is terminated by Us for all certificate holders in your state; c) the date we receive your written request to terminate coverage; d) the last day of the period for which the premium is paid; e) the last day of the period for which premium has been paid following the date a dependent ceases to be a dependent as defined; or f) the date a covered person enter full time military service. Upon written request within 30 days of entering the military, We will refund any unearned premium pro-rata with respect to such person.

At least 45 days prior to written notice will be given to you if We terminate your coverage for any reason, except nonpayment of premium.

If We discontinue the Policy form or plan of Insurance, We will provide you 90 days written notice and the opportunity to purchase without submitting proof of good health, any similar insurance coverage which we offer in that state. If we uniformly discontinue all coverage in a market in your state of residence, We will provide you at least 90 days written notice before the coverage terminates.
The continued coverage will cover the covered person and his insured dependents.

Continued coverage will terminate on the earlier of: a) the date 18 months after the date on which the group coverage would otherwise have terminated because of termination of the group membership. B) if the covered person fails to make timely payment of premium, the end of the period for which premium payment was made; or c) the date the Policy is terminated and is not replaced by another group policy within 31 days.

If a group policy is replaced, covered persons covered under continued coverage shall remain under such coverage under the replaced policy until as provided in the termination of Continued Coverage provision.

In the Event of Dissolution of Marriage

If your marriage is dissolved by a valid decree of dissolution and if your spouse is a covered person on the date of the decree of dissolution then the dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the dependent spouse continues coverage pursuant to this provision, we will issue him or her a new Certificate as evidence of coverage under the Policy.

For a Dependent child reaching the limiting age

If a dependent child no longer qualifies as a dependent, then the dependent child's coverage will continue in force under the policy, subject to its provisions, if the dependent child pays the first premium required for continued coverage within 31 days after the date her or she no longer qualifies as a dependent child.

If the dependent child continues coverage pursuant to this provision, we will issue him or her a new certificate as evidence of coverage under the Policy.

# MEDICAL EXPENSE BENEFITS

We will pay for Covered Charges incurred by the covered person due to Sickness or Injury while covered under the Policy. Covered charges as defined and limited are shown on the Schedule and are, during a Calendar Year, subject to: a) deductible; b) insured percent; c) our-of-pocket maximums; d) coordination of benefits; e) the lifetime aggregate maximum amount; and f) definitions, limitations, exclusions and other provisions of the Policy.

**Deductible:** A dollar amount of covered charges a covered person must pay each calendar year before benefits are paid. The deductible is shown in the Schedule. A new deductible will apply each calendar year.

**Insured Percent:** The percentage of covered charges we pay for covered charges during each calendar year after the deductible is satisfied. The insured percent is shown in the Schedule.

**Calendar Year Maximum:** The maximum amount that will be paid in benefits within a calendar year.

**Lifetime Aggregate Maximum Amount:** The maximum amount of benefits We will pay while a covered person is covered under this Certificate. The Lifetime Aggregate Maximum Amount is inclusive of all benefit amounts received under this Certificate. The Lifetime Aggregate Maximum Amount is shown on the Schedule.

**Our of Pocket Maximum:** The amount of covered charges a covered person must pay during a Calendar Year before his or her benefits are paid at 100%. The Out-Of-Pocket Maximum is in addition to the Deductible and applies only to out-of-network expenses. The Out-of-Pocket Maximum is stated in the Schedule.

# GENERAL EXCLUSIONS

We won't pay benefits for:

Treatment, services or supplies which:

- Are not Medically Necessary
- Are not prescribed by a Doctor as necessary treatment to treat a Sickness or Injury
- Are determined to e Experimental/Investigational in nature by Us
- Are received without charge or legal obligation to pay
- Would not routinely be paid in the absence of insurance
- Are received form family members
- Are received outside the United States

Expenses incurred as a result of loss due to war, declared or undeclared; service in the armed forces of any country.

Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.

Expenses incurred as a result of suicide or attempted suicide or intentionally self-inflicted injury whether sane or insane.

Injury or sickness arising out of or in the course of employment which is compensable under any Worker's Compensation or Occupational Disease Act or Law.

Cosmetic Surgery other than:

a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
b) reconstructive surgery because of a congenital disease or anomaly, except as provided for Dependent newborns.

Injury due to being legally intoxicated, as defined by the jurisdiction in which an accident occurs.

Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.

Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial scheduled airline.
Any service or supply not specifically listed as a covered charge.
Sexual reassignment surgery and related expenses.
Routine physical examinations, health examinations or preschool physical examinations including routine care of a newborn infant, other than Hospital nursery expense of a dependent newborn baby.
Temporomandibular Joint Dysfunction (TMJ)
Expenses incurred as a result of dental treatment or dental x-rays, except as specifically provided and then only when injury occurs to sound natural teeth.
Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription, therefore, or radial keratotomy or laser surgery; hearing aids or prescriptions or examinations, except as required for repair caused by injury.
Treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted contraception.
Manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, application of heat or cold.
Expenses to the extent they are paid under Medicare or any other government insurance plan (except Medicaid).
Expenses covered by automobile "no fault" contracts (group, group-type or individual).
Chelation treatments.
Artificial limbs or prosthetics, except as specifically provided.

## PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first twelve (12) months following a Covered Person's effective date of coverage under this Policy.

The Pre-existing Condition Limitation does not apply to: a) a newborn Dependent Child; or b) a child adopted by you or placed with you for adoption, if the adoption or placement for adoption occurs while you are covered under this Policy.

# COORDINATION OF BENEFITS PROVISION

The following provisions are applied to determine which Insurance Plan pays benefits first when a Covered Person is covered by tow or more plans. A Plan that pays first is called "Primary". All other plans called "Secondary".

If these provisions apply, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The Benefits of the Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits first before another plan; but
(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of the Plan".

Definitions:

"Plan" is any of these which provide benefits or services for, or because of, medical or dental or treatment.

(1) Group Insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.) as amended form time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"This Plan" is not part of the group contract that provides benefits for health care expenses.

"Primary Plan/Secondary Plan": The order of benefit determination rules state where this plan is a primary plan or secondary plan as to another plan covering the person.

(1) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
(2) When this Plan is a Secondary Plan, its benefits are determined after those of he other plan and may be reduced because of the other plan's benefits.

(3) When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and my be a Secondary plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

(1) The difference between the cost of a private room and a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
(2) When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year. However it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules:

General: When there is a basis for a claim under this Plan and another plan, this plan is a Secondary plan which has its benefits determined after those of the other plan, unless:
(1) The other plan has rules coordinating its benefits with those of this Plan; and
(2) Both those rules and this Plan's rules, in subsection B below, require that this Plan's benefits be determined before those of the other plan.

Rules: This Plan determines its order of benefits using the first of the following rules which apply:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that : if the person is also a Medicare beneficiary, Medicare is:
    a. Secondary to the plan covering the person as a dependent; and
    b. Primary to the plan covering the person as other than a dependent, for example a retired employee.

(2) Dependent Child/Parents not separated or divorced. Except as state in subsection (b) (3) below, when this plan and another plan cover the same child as a dependent of a different person, called "parents".
    a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but
    b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c. However, if the other plan does not have the rule described in subsection (2) (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits the rule in the other plan will determine the order of benefits.

(3) Dependent Child/ Separated or Divorced. If tow or mare plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with the custody of the child; and
    c. Finally, the plan of the parent not having custody of the child

d. However, if the specific terms of a court decree state that one of the parents is responsible for health insurance expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

(4) Dependent/ Child/Joint Custody: If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection (2) (b) above.

(5) Active/Inactive Employee. The benefit of a plan which covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination.

a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
b. Second, the benefits under the continuation coverage.

(7) Longer/Shorter length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plans which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

Effects on the Benefits of the Plan

(1) When this Section applies. This section applies when, in accordance with the above Section, "Order of Benefit Determination Rules," This Plan is Secondary plan as to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (2) immediately below.
(2) Reduction in this Plans Benefits. The benefits of this Plan will be reduced when the sum of:
(a) The benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
(b) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable expenses.
(c) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply this COB rules. Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Insurer needs not tell, or get

the consent of, any person to do this. Each person claiming benefits under this Plan must give insurer any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Insurer 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 case value of the benefits.

Right of Recovery

If the amount of the payment made by insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of: a) The persons it has paid or for whom it has paid; b) Insurance companies; or c) other organizations.

# PREFEFFED PROVIDER BENEFIT

We encourage Covered Providers by providing benefit incentives when Preferred Providers are used.

In the event of an emergency, services rendered by any Hospital due to and within the first 24 hours after the onset of the emergency are covered as if the service had been provided by Preferred Hospital. After the first 24 hours, service rendered by a non-preferred Hospital to treat the emergency will continue to be covered as if rendered by a preferred provider only until the covered person can reasonably and safely be transferred to a preferred Hospital.

In the event a covered person is traveling or away from home, needs medical attention, and cannot use a Participating Provider for the area, contact our Customer Service department. We will refer the covered person to a participating provider that may be available in the area nearest to such person at the time. If there is no participating provider available benefits for covered charges will be subject to the reduced insured percentage and out-or-pocket maximum.
A covered person is not required to seek treatment from a preferred provider. Each covered person is free to elect the services of a provider and benefits payable will be made in accordance with the terms and conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a preferred provider or to their respective staff or Doctors. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the preferred provider, their staff or Doctors.

**Out-of-Network:** Any Hospital or Doctor that is not a member of the preferred provider network arrangement that has contracted with Us.

**Preferred Provider:** Any Hospital or Doctor that has contracted with Us to provide services, as described in this Certificate, through a preferred provider network arrangement, to be reimbursed at discounted rates.

# CLAIM PROVISIONS

**Notice of Claim:** Written notice of claim for loss must be given to Us or Our authorized representatives within 30 days after a covered loss starts, or, because of incapacity or some similar reason, as soon as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

**Claim Form:** Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished by Us within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss submitting, within the time fixed in the Policy for filing the Poof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**Proof of Loss:** Written Proof of Loss must be given to Us or Our authorized representative within 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as was reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

**Time of Payment of Claims:** Benefits will be paid as soon as We receive proper Proof of Loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

**Payment of Claims:** Benefits will be payable to You or the medical services provider if We have received a valid assignment by the covered person.

If any benefit is payable to the estate of a covered person or to a covered person who is a minor or otherwise not competent to give a valid release, we may pay the benefit, up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the covered person who is considered by Us to be equitably entitled to the benefit.

Subject to any written direction of the covered person or of the legal or natural guardian of the covered person, if the covered person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular hospital or person.

**Physical Examination:** We, at Our expense, shall have the right and opportunity to examine the covered person as it may reasonably be required while a claim is pending.

**Legal Actions:** A legal action may not be brought to recover on this Policy within 60 days after written proof of loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

**Subrogation:** When benefits are paid to or for a covered person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such covered person against any person who might be acknowledgedly liable or found legally liable by Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefit was paid. Such subrogation rights shall extend only to Our recovery of the benefits we have paid for such hospitalization and treatment and We shall pay fees and costs associated with such recovery.

If the Director of Serve America Assurance or his or her designee, upon being petitioned by a covered person, determines that the exercise of subrogation by Us is inequitable and commits an injustice to the covered person, subrogation under this provision is not allowed. This determination by the Director or his or her designee may be appealed by Us.

# PREMIUM

**Payment of Premium/Due Date:** All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at Our home office of by Our authorized representative.

**Returned or Dishonored Payment:** If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under State law. A dishonored check shall be considered a failure to pay Premium and coverage will lapse.

**Change in Premium Rates:** We have the right to change the table of premium rates from time to time. Premiums will change if dependents are added or removed. If benefits are changed, or if a new table of premium rates applies. Premiums will also increase as your age and the age of other covered persons increase. A change in the table if premium rates or a premium increase due to age will be effective on the first premium due date following such written notice. We can only change the table of premium rates if We change it for all the policies with this form in your state.

**Grace Period:** We allow a grace period of 31 days for the payment of premium after the first premium is paid. Coverage is in force during the grace period. If a t least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date of the non-renewal is to be effective. If you send written notice to Us that you are not renewing your coverage, then the grace period will not apply after the date the non-renewal is effective.

Coverage terminates on the last day for which premium has been paid.

**Reinstatement:** If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the business.

If We do not require an application for reinstatement and accept premium, then We may issue a conditional premium receipt. If we approve the application, then insurance will be reinstated as of the date of Our approval. If we do not approve the application, then We will notify you in writing within 45 days after the date of the application.
If we do not notify you within 45 days, then coverage will be reinstated on the 45th day after the date of the conditional premium receipt.

The reinstated Certificate will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, Your rights and Ours will be same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

# *GENERAL PROVISIONS*

**Entire Contract Changes:** The policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

Failure by Us to enforce any Policy provision, shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

**Time Limit on Certain Defenses:** After 2 years from the covered person's effective date, no misstatements, except fraudulent misstatements, made by the covered person in the application for such coverage shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the 2 year period.

No claim for loss incurred commencing after 2 years from the covered person's effective date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage.

**Misstatement of Age:** If the age of the covered person has been misstated, all amounts payable under the Policy will be such as the premium paid would have been if purchased at the correct age.

**Other Insurance with Us:** Insurance effective at any one time on the insured under a like policy or policies with Us is limited to one such Policy elected by the Insured, his beneficiary or his estate, as the case may be and We will return all premiums paid for all other such policies.

**Non-Participating:** This Certificate is non-participating. It does not share in Our profits or surplus earnings.

**Conformity with State Statutes:** If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

**Workers Compensation:** This certificate is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Clerical Error:** If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: a) the Policyholder makes a written request for coverage on a form approved by Us; and b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the covered is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

**Information and Records:** We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a covered person's coverage terminates.

# SERVE AMERICA ASSURANCE

## SCHEDULE

**POLICYHOLDER**

Realty Benefits Associates
1351 Forest Ave
PMB 124
Staten Island, New York 10302

## MEDICAL EXPENSE BENEFITS

| | |
|---|---|
| LIFETIME AGGREGATE MAXIMUM AMOUNT PER COVERED PERSON: | $1,000,000 |
| ANNUAL CALENDAR YEAR MAXIMUM AMOUNT PER COVERED PERSON: | $250,000 |
| DEDUCTIBLE, PER CALENDAR YEAR, PER COVERED PERSON: | $10,000 |
| INSURED PERCENT (EXCEPT AS SPECIFICALLY STATED IN CHARGES) | |
| IN-NETWORK: | 100% |
| OUT-OF-NETWORK: An Additional Deductible of $10,000 at 80%/20% then | 100% |

OUT-OF-POCKET MAXIMUM APPLIES ONLY TO OUT-OF-NETWORK SERVICES AND IS IN ADDITION TO THE DEDUCTIBLE.

## COVERED CHARGES

Covered Charges are treatment, services or supplies incurred for:

### INPATIENT

- Hospital room and board and general nursing care while Hospital Confined, up to the daily semi-private room rate
- Hospital miscellaneous charges, such as the cost of the operating room, laboratory tests, x-ray examinations.
- Speech and occupational therapy
- Intensive Care Unit/Hospital expenses, not to exceed 2 times the Hospital rate for semi-private room
- Doctor's fee for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession
- Anesthetist expenses
- Assistant surgeon's expense
- Pathologist expense
- Radiologist's expense
- Nurse expense for private duty nursing, when prescribed by the attending Doctor, up to $250 a day, not to exceed $10,000 per Calendar year
- Doctors visits
- Physiotherapy
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivative not replaced; charges for processing and administration of blood or blood derivatives
- Treatment of Mental or Nervous Disorders limited to a maximum benefit of $10,000 per lifetime
- Treatment of alcoholism

### OUTPATIENT

- Doctor's fees for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.
- Anesthetist expense
- Assistant surgeon's expense
- Doctor's visits
- Physiotherapy
- Emergency room expenses and supplies
- Diagnostic x-ray expense
- Laboratory services expense
- CAT Scan/MRI expense
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivatives not replaced; charges for processing and administration of blood or blood derivatives

### OTHER

- Rental and expense of wheelchairs, hospital beds and other Durable Medical Equipment of this type, not to exceed the purchase price
- Casts, splints, braces, trusses, crutches and other devices of this type

- Dental treatment for injury to sound natural teeth
- Rental of mechanical equipment for medical or surgical treatment, not to exceed the purchase price
- Home health care expense up to $250 per week not to exceed $10,000 lifetime
- Hospice care expense for up to six months per lifetime
- Bereavement counseling received from a hospice for the immediate family of the deceased covered person, up to $500 lifetime
- Skilled nursing care up to $250 per week not to exceed $10,000 lifetime. Confinement must be prescribed by the attending Doctor. Skilled Nursing Care benefits will be paid only after the covered person was Hospital Confined for at least 3 consecutive days and Skilled Nursing Care begins within 14 days of such Hospital Confinement
- Ambulance expense, up to a maximum benefit of $250 per trip, not to exceed $1,000 per calendar year
- Prescription expense, up to a maximum benefit of $10,000 lifetime

Applies Only to Dependent Children: Care and treatment of congenital cleft in the lip or palate or both, including but not limited to:

- Oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate
- Prosthetic treatment such as obdurators, speech appliances, and feeding appliances
- Prosthodontic treatment and management
- Otolaryngology treatment and management
- Audio logical assessment, treatment, and management performed by or under the supervision of a Doctor of medicine; including surgically implanting amplification devise; and
- Physical therapy assessment and treatment

Hospital Confinement for at least 48 hours following a mastectomy. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending Doctor.
Prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the patient's attending Doctor.

# SERVE AMERICA ASSURANCE
# PRIVACY NOTICE

At SERVE AMERICA ASSURANCE INSURANCE COMPANY, we know the importance of an individual's right to privacy. That's why protecting information that personally identifies you is high priority and a matter we take very seriously.

Our primary goal is, and will continue to be, provide you with competitive, exceptional quality insurance products to meet the long term financial needs or you and your family.

We want to assure you that the personal, financial and medical information you share with us for applying coverage to claims is the cornerstone in providing you the highest quality coverage we can for the most affordable price. That information, unique to you, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with you.

The following is a summary of our privacy policy and practices.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION
In order for SERVE AMERICA ASSURANCE to provide and administer the products we offer, we collect personal information about you. Some of the information we collect about you is non-public. The non-public information we collect is obtained from the following sources:

Information we receive from you on your application for insurance or other forms, such as your name, address, telephone number, age, social security number, and beneficiary designation.

Information about your transactions with us and our affiliates, such as the type of insurance products you buy, the premium you pay, the method of purchase and your payment history.

Information we receive from third party reports such as consumer reporting agencies, credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.

INFORMATION WE DISCLOSE
SERVE AMERICA ASSURANCE does not disclose any non-public information about our policyholders or former policyholders to anyone, except as permitted or required by law.

We may also disclose all of the information we collect as described above, with the following:

Affiliates – We may share information with our affiliates.

Service Providers – We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction that you request or authorize; to develop or maintain computer software; or to perform market research.

Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY
Your medical information is kept confidential. We will not use or share, internally or with third parties, your medical information except for the purpose of:

- Underwriting;
- Administering your policy or claim
- As permitted or required by law; or
- As authorized by you.

SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION
We restrict access to nonpublic information about you to those employees (or people working on your behalf under confidentiality agreements) who need to know the information in order to provide products and services to you. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your non-public personal information.

Exhibit 7

## Rousseau, Jule

**From:** Bart Posey [bposey@sdsfirst.com]
**Sent:** Thursday, February 04, 2010 9:59 AM
**To:** Rousseau, Jule
**Subject:** FW: New Account

-----Original Message-----
From: Rick Bachman [mailto:rbachman@sdsfirst.com]
Sent: Thursday, February 04, 2010 8:48 AM
To: 'Bart Posey'
Subject: FW: New Account

-----Original Message-----
From: wworthy35@comcast.net [mailto:wworthy35@comcast.net]
Sent: Thursday, October 23, 2008 10:15 AM
To: Rick Bauchman
Subject: Fw: New Account

Sent from my Verizon Wireless BlackBerry

-----Original Message-----
From: wworthy35@comcast.net

Date: Thu, 23 Oct 2008 14:58:04
To: Angie Posey<aposey@sdsfirst.com>
Subject: Fw: New Account

Angie,

Below you will find the new escrow account.

Please let me know the amount and when you wire it. I need it ASAP!

Thanks,

Wm
------Original Message------
To: Rick Bauchman
Sent: Oct 6, 2008 7:50 AM
Subject: Fw: New Account

New account!

------Original Message------
To: Rick Bauchman
Sent: Oct 3, 2008 11:21 AM
Subject: New Account

Rick,

Below you will find the new account information for Beema

Bank:

First Citizens Bank

201 Blythewood Road
Blythewood, S.C. 29016

Account name:

Nationwide Administrators, LLC.
Escrow account for Beema Insurance Co, LTD.

Account #: 083010850201

Routing #: 053906041

Please use this account for all wire tranfers.

Thanks,

William

Sent from my Verizon Wireless BlackBerry

Exhibit 8

**Bart Posey**

---

**From:** wworthy35@comcast.net
**Sent:** Thursday, September 03, 2009 12:08 PM
**To:** William L. Hendricks
**Cc:** Bart Posey; Katie D. Cauthen
**Subject:** Serve America
**Attachments:** Serve America.pdf

Bill,

I have been instructed to send this to you regarding Serve America. Assuming Attorney Client privileges.

Serve America is a Protected Cell Captive owned by Beema, located in Pakistan. It reinsures the ATA association 100%. The attached letter illustrates the captive as well. If you have any further questions, please let me know or call me.

Thanks,

William

Exhibit 9

Exhibit 10

**Bart Posey**

**From:** Bart Posey [bposey@sdsfirst.com]
**Sent:** Thursday, October 22, 2009 1:19 PM
**To:** 'William L. Hendricks Jr.'
**Subject:** FW: Serve America

---

**From:** Comcast [mailto:wworthy35@comcast.net]
**Sent:** Wednesday, October 21, 2009 9:58 PM
**To:** Bart Posey
**Cc:** <bposey@sdsfirst.com>; William L. Hendricks Jr.; Rick Bachman
**Subject:** Re: Serve America

Ok, thank you .

William

On Oct 21, 2009, at 6:33 PM, "Bart Posey" <bposey@sdsfirst.com> wrote:

<image001.gif>

October 21, 2009

Via E-Mail:

Mr. William Worthy
**Southeast Insurance Advisors, LLC**
Post Office Box 642
Isle of Palms, SC 29451

Re: Beema/ServeAmerica
Our File No.: 19592.30001

William:

As you know Smart Data Solutions who has been working with you based upon your representations regarding the relationship of Beema/ServeAmerica for quite some period of time now which has resulted in numerous investigations by various departments of insurance, including but not limited to the latest and most troublesome investigation by Leslie Landwert the Oklahoma Department of Insurance.

Each and every time that SDS has been confronted with these types of investigations I've had no alternative but to refer them to my lawyer who has spent an enormous amount of time attempting to pacify the investigations, respond to the investigations

and/or accommodate them, or both. On numerous occasions, including the latest occasion with Leslie Landwert, we have advised, at the direction of you, on behalf of Beema/ServeAmerica that those entities would be responding directly to the various departments regarding the premium issues, the account issues, etc. Despite our statements to that effect, no information, according to the investigators, has been received from Beema/ServeAmerica and in fact the e-mails from the Oklahoma Department of Insurance are much more pointed than that.

Specifically Oklahoma has stated in unequivocal terms that Beema has made no statements to them despite my attorney advising the various departments of insurance, based upon your statement and assurances, that a written statement is forthcoming responding to the request for information from Beema/ServeAmerica regarding insured's' payments, back accounts, etc. That, as with all other assurances has not come to fruition.

While you continue to assert that Beema Pakistan, has sent the letter, which you ultimately forwarded to us which was both factually incorrect, according to the other documentation you have been provided including the various Beema policies that we have in fact produced to various departments of insurance response to investigative subpoenas and representations you had previously made, and likewise was directly contrary to the documentation and policy what you advised us we in turn have advised the various DOIs, in reliance upon your assurances, representation and the actual policies we've been provided indicating Beema as in fact the insured as referenced in the letters directly from you. Upon being questioned about that letter (undated and unaddressed) you indicated that you were not certain if it had been sent; however, I am certain that we were never consulted regarding the contents thereof and have never seen a copy of any such letter that was actually apparently authored and/or sent to the respective DOIs although you've indicated that in fact that was a template for the letter that was to be sent. That letter specifically states:

> "BPCL has at no time issued any insurance policy to any individual or other legal entity resident in any other state/territory of the USA."

The letter goes on to state:

> "Again for the record BPCL is regulated under the laws of Pakistan. BPCC does not own any subsidiary, company or corporate legal entity outside Pakistan."

It is baffling to me that the letter and/or proposed letter that you referenced to be the template containing the statements that in fact are contained therein which are directly contrary to what has been represented to us regarding Beema binding coverage. It is further directly contrary to the letter from you dated 3/10/08, undated letter you provided to us, allegedly from Collin Youell, an alleged director of Beema, not to mention the numerous policies we've been provided from Beema, according to the documentation.

Despite the statements in this undated template, your letter of 3/10/08 states:

> "It is understood that the benefits of the above listed plans are 100% insured and underwritten by and for Beema Insurance Company, LTD and its offshore capital ServeAmerica."

These statements are directly contrary to the template letter you just recently provided to me.

Since that time, I have questioned you repeatedly on exact the status of ServeAmerica and/or Beema closing on a United States insurance company which you have repeatedly indicated to me was days away from transpiring. To date, I've received no documentation substantiating any of those statements.

Of late, due to the expense associated with defending these investigations, we have again called upon Beema through you as their representative to step in, respond, support or otherwise do something to clarify Beema's position in this matter and of course the latest template letter that was supposed to help is directly contrary to what we've been told, represented to various DOIs and what the documentation that we've been provided states.

Based upon the above, the fact that these investigations continue, that we received no assistance whatsoever, been provided no input of counsel on behalf of Beema and/or been reimbursed and/or indemnified or held harmless for any of the expense incurred, not to mention the irreparable harm SDS is experiencing as a result of these numerous investigations we have yet to receive any substantive help and/or documentation and in fact despite promises to the contrary we have made, to various DOIs, after being assured of participation by Beema nothing, has been sent to them and/or forwarded to them. This again puts SDS in a very difficult situation as the normal circumstance would be that Beema would hold harmless and indemnify the TPA under the terms of the agreement especially with regard to these types of matters and would be the primary respondent on behalf of same.

Based upon advice of counsel, unless and until we receive some assurance and/or documentation of the exact relationship between Beema, ServeAmerica and/or any other captive and/or ServeAmerica or other entity I have been instructed to decline to make further payments on the above.

William, the necessity of this information is clear, the promises that have been made are clear and we still stand here literally more than a year after this relationship has been undertaken with no additional information other than your continued assurances, none of which have been documented in any regard. Unless and until we receive a response satisfactory my counsel, I have been advised to cease from making any further payments and likewise do not intend to continue to rely upon your representations when in fact none of them have come into fruition.

Lastly, this will advise that SDS demands that Beema/ServeAmerica and/or such other entities as you have alluded and referenced fully indemnify and hold harmless SDS from any and all damage, attorney's fees, fines, or otherwise resulting from the failure of the responses to be forthcoming from Beema and based upon the failure to abide by the assurances made to SDS upon which we have relied.

Sincerely,

/BP

BART POSEY

Exhibit 11

**Bart Posey**

---

**From:** wworthy35@comcast.net
**Sent:** Tuesday, November 17, 2009 4:20 PM
**To:** Bart Posey
**Cc:** William L. Hendricks
**Subject:** ATA Block
**Attachments:** Friendly_Soceity[1].pdf

Bart,

Attached is a letter of committment that the SA block has been assumed by Ittefaq General Insurance Company. The Friendly Society is an old term that is used to contract reinsurance slip. This is the first stag where SA has transferred the risk to Ittefaq. Tomorrow, a reinsurance contract will be issued to ATA. The two possible fronts on the table are State National and New Hampshire Life. They are discussing the opportunity and issues and now that a very large reisurer( Ittefaq General) is in place to take the risk for either carrier, it should be easier.

Thanks,

William

**Exhibit 9**

Copy of Exhibit 9
from William Hendricks
Inadvertently omitted
from Court filing

"Ref : _____ Date : _____

Department of Insurance
State of .....
.....
.....
.....

Dear Sirs,

Our attention has been drawn to some proclaimed Cease & Desist Orders being issued by the Departments of Insurance of several States in the USA, in which reference has been made to "Beema" and/or "Beema Group" or "Beema Insurance". Due to the similarity and common use of the word "Beema" appearing in the name of our company also, Beema Pakistan Company Limited ("BPCL"), inferences are being drawn to implicate BPCL in these matters. (Together with a protective cell /rent a captive know as Serve America Assurance)

We have, earlier, already clarified our position to the Ohio Department of Insurance in this regard and, through this letter, we seek to clarify again that BPCL is a public listed company duly incorporated in 1960 under the laws of Pakistan and is duly licensed with the relevant regulatory authority in the country to carry on the business of general insurance.

BPCL has at no time prior to this issued any insurance policy to any individual or other legal entity resident in any other territory/State of the USA. Any other averments to the contrary are false and are specifically denied.

Other than reinsurance treaties duly approved by the relevant regulatory authority in Pakistan, BPCL has also not appointed any "agent" outside Pakistan and any all such representations made by any other person or party have been made by such persons/parties entirely at their own risk as to costs and consequences and BPCL specifically denies the same. BPCL further reserves its right to seek appropriate legal remedy against any such scrupulous persons / parties to redress the damage caused by such misrepresentation.

Again, for the record, BPCL is regulated under the laws of Pakistan. BPCL does not own any subsidiary company or corporate legal entity outside Pakistan. Any "findings" or averments to the contrary are not based on facts on record and are specifically denied.

The Cease & Desist Orders have been made *ex parte* without due process of law and we reserve our right to safeguard and protect at all times the interest of our shareholders and policy holders under suitable legal guidance.

Wherever possible, we are seeking copies of all relevant documents in this regard, together with duly attested, certified true copies of the proclaimed Orders, enabling us to take suitable action at our end.

Yours truly,

for Beema Pakistan Company Limited,