UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

KOBA KVIRIKASHVILI, and all others similarly situated Plaintiff(s) v. UNITED STATES FIRE INSURANCE COMPANY; BLUE STAR CLAIMS, LLC; and DOES 1 through 10, inclusive, Defendant(s)	Civil Action No. Jury Trial Demanded

Koba Kvirikashvili ("Plaintiff"), on behalf of himself and all others similarly situated, alleges as follows:

I. INTRODUCTION

1. Subrogation is a legal right that allows an insurance company to recover money it has paid out on account of a loss.

2. Upon information and belief, despite various anti-subrogation enactments, Defendants (as defined herein) sought to unlawfully encumber and obtain proceeds of personal injury claims throughout the United States under the guise of subrogation regarding hundreds, if not thousands, of individuals.

3. This is an action brought to stop Defendants from continuing their conduct and to require disgorgement of their unlawful gains.

4. Absent this action, Defendants' inappropriate attempts would continue unabated.

II. THE PARTIES

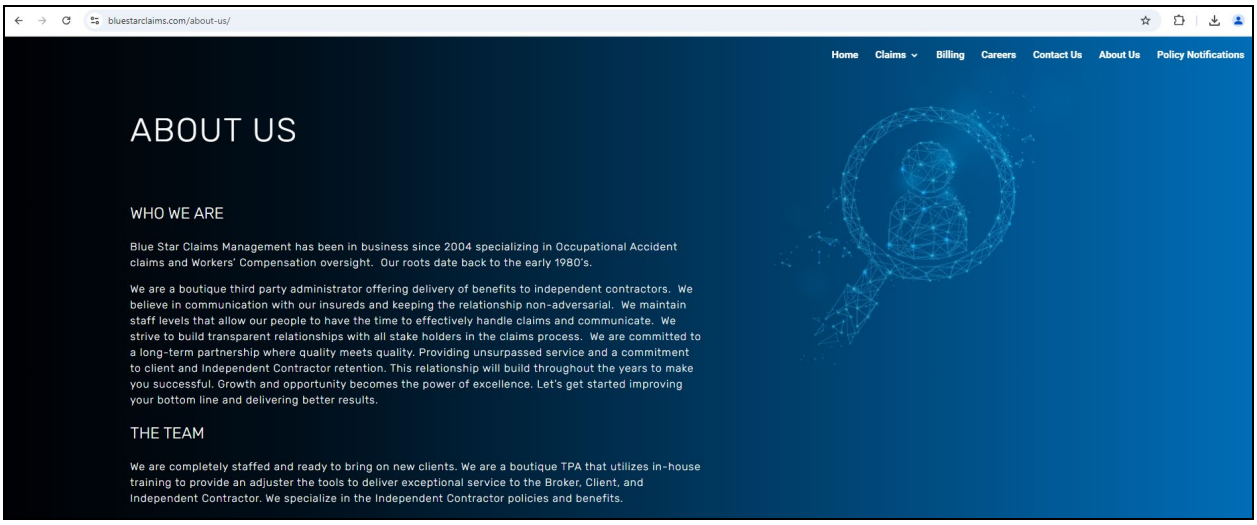
5. Plaintiff is an adult individual citizen of the Commonwealth of Pennsylvania.

Plaintiff resides in Philadelphia County.

6. Defendant United States Fire Insurance Company ("USFIC") is a corporation organized under the laws of the State of Delaware, with its principal place of business at 5 Christopher Way, Eatontown, NJ 07724. It is authorized to transact insurance business in all states and the District of Columbia.

7. Defendant Blue Star Claims, LLC f/k/a Blue Star Claims Management, LLC ("Blue Star Claims") is a limited liability company organized under the laws of the State of Arizona, with its principal place of business at 21001 North Tatum Boulevard Suite 1630-646 Phoenix, AZ 85050, and mailing address at 8825 N. 23rd Avenue Suite 100 Phoenix, AZ 85021.

8. On its website, Blue Star Claims describes itself as follows:



https://www.bluestarclaims.com/about-us/ (last visited on September 23, 2025).

9. Plaintiff is unaware of the names and capacities of those defendants sued as DOES 1 through 10, but will seek leave to amend this Complaint once their identities become known to Plaintiff. Upon information and belief, Plaintiff alleges that at all relevant times each defendant, including the DOE defendants 1 through 10, was the officer, director, employee, agent, representative, alter ego, or co-conspirator of each of the other defendants, and in engaging in the

conduct alleged herein was in the course and scope of and in furtherance of such relationship.

10. Unless otherwise specified, Plaintiff will refer to all defendants collectively as "Defendants" and each allegation pertains to each Defendant.

11. At all times material hereto, Defendants acted and/or failed to act in person and/or through duly authorized agents, servants, workmen, and/or employees, acting within the scope and course of their authority and/or employment for and/or on behalf of Defendants.

III. JURISDICTION AND VENUE

12. This Honorable Court has jurisdiction pursuant to 28 U.S.C. § 1332, 28 U.S.C. § 1367, and the Declaratory Judgment Act, 28 U.S.C. § 2201 et seq.

13. The Eastern District of Pennsylvania is the proper venue for this litigation, because:

a. Plaintiff is a resident of the Eastern District of Pennsylvania and Defendants' wrongful conduct was directed to and was undertaken within the territory of the Eastern District of Pennsylvania; and

b. Defendants conduct a substantial portion of their business in the Eastern District of Pennsylvania.

IV. STATEMENT OF CLAIMS

A. BACKGROUND

14. On December 1, 2023, Plaintiff was involved in a motor vehicle accident that caused Plaintiff to suffer from various serious physical injuries.

15. At the time of their accidents, Plaintiff was making a delivery for DoorDash, Inc. ("DoorDash") – "a technology company that facilitates food delivery through its online platform [that] connects customers, restaurants, and delivery drivers."[1]

[1] Magana v. DoorDash, Inc., 343 F.Supp.3d 891, 895 (N.D.Cal. 2018).

16. DoorDash delivery drivers are independent contractors.

17. Independent contractors serving as delivery drivers, such as DoorDash delivery drivers and Plaintiff, are not entitled to receive benefits under the applicable workers' compensation laws when making deliveries.

18. Instead, they receive benefits under a so-called "Occupational Accident" insurance policy, issued by USFIC and administered by Blue Star Claims ("USFIC Policy").

19. After his accident, Plaintiff made claims against the USFIC Policy and went to various medical providers for evaluation and treatment of his injuries.

20. Thereafter, Blue Star Claims sent a letter to Plaintiff, dated December 29, 2023, wherein Blue Star Claims identified itself as "the Third Party Administer of claims on behalf of [USFIC]" with respect to the USFIC Policy.

21. In that correspondence, Blue Star Claims, on behalf of USFIC, wrote that Plaintiff's "claim is being accepted for occupational accident benefits for injuries sustained on 12/1/2023."

22. This letter further stated:

> [P]lease note the Right of Recovery/Subrogation clause in your policy. This clause states that you must refund to us any overpayment of benefits that occurs because a third party was liable to pay certain of your expenses due to a wrongful act, negligence or omission. This refund will **equal the amount we paid** . . . If the refund is due from another person or organization, you must help us obtain the refund. Please refer to the Policy and contact us with any questions.

(Emphasis added).

23. USFIC then made payments to various medical providers on account of Plaintiff's injuries.

24. On or about February 16, 2024, Blue Star Claims, on behalf of USFIC, sent a letter to Plaintiff's counsel (via certified mail), with a subject line "RIGHT OF RECOVERY NOTICE

(INITIAL)."

25. In relevant part, this letter stated:

> Dear Kalikhman & Rayz:
>
> We are the Third Party Administer of claims on behalf of United States Fire Insurance Company in reference to this accident claim. We represent US Fire in the collection of the Right of Recovery for amounts paid for the occupational injury claims. We are seeking reimbursement for all medical, expense and indemnity costs paid out on this claim.
>
> Please consider this our Initial Right of Recovery Notice. We are seeking reimbursement for all medical, expense and indemnity costs paid out on this claim. Our total amount paid to date is $**2,829.95**. ***Please Note: This figure is not final.** We will continue to update you on a regular basis.

26. Approximately three months later, on May 23, 2024, Blue Star Claims, on behalf of USFIC, sent another correspondence to Plaintiff's counsel with a subject line "RIGHT OF RECOVERY NOTICE (UPDATE)."

27. In relevant part, this letter stated:

> Dear Kalikhman & Rayz:
>
> We are the Third Party Administrator of claims on behalf of United States Fire Insurance Company in reference to this accident claim. We represent United States Fire Insurance Company in the collection of the Right of Recovery for amounts paid for the occupational injury claims. We are seeking reimbursement for all medical, expense and indemnity costs paid out on this claim.
>
> Please consider this an update to our Right of Recovery amount for all medical, expense and indemnity costs paid out on this claim. Our total amount paid to date is $31,805.27. ***Please Note: This figure is not final.** We will continue to update you on a regular basis.

28. On January 7, 2025, Blue Star Claims, on behalf of USFIC, sent another correspondence to Plaintiff's counsel, with a subject line "RIGHT OF RECOVERY NOTICE/REQUEST FOR REIMBURSEMENT (FINAL)."

29. In relevant part, this letter stated:

> Dear Kalikhman & Rayz:
>
> We are the Third Party Administrator of claims on behalf of United States Fire Insurance Company in reference to this accident claim. We represent United States Fire Insurance Company in the collection of the Right of Recovery for amounts paid for the occupational injury claims. We are seeking reimbursement for all medical, expense and indemnity costs paid out on this claim.
>
> Our total amount paid is **$41,183.01** and we are requesting immediate reimbursement of this amount. ***This is our final figure and therefore our final demand.**

30. In effect, by way of the correspondence identified above, Blue Star Claims, on behalf of USFIC, sought to subrogate any payments made on behalf of Plaintiff from the money Plaintiff would recover.

31. By September of 2025, Plaintiff settled his claim against the third party responsible for his accident, as well as all additional insurance companies providing coverage for Plaintiff's injuries incurred in the accident at issue.

32. After receipt of the settlement proceeds on September 19, 2025, the sum of $45,000.00 has been escrowed on account of the demands for payment sent on behalf of USFIC.

B. USFIC POLICY

33. On October 22, 2024, by way of an email, Plaintiff's counsel requested from Blue Star Claims "a **complete copy** of the underlying [USFIC P]olicy effective on the date of loss, including but not limited to any and all rights of subrogation language with accompanying certificates." (Emphasis supplied).

34. The following day, an adjuster from Blue Star Claims (with a title "Subrogation Lead") responded by providing a copy of a 34-page, "Blanket Occupational Accident Certificate" ("Certificate"). A true and correct copy of this document is marked and attached hereto as Exhibit "1."

35. The Certificate proclaims that it "is a legal contract between [y]ou and [u]s to provide coverage for Occupational Accidents" that applies to "[a]ll [i]ndependent [c]ontractors not domiciled in California performing [c]overed [a]ctivities for DoorDash," but that "THIS IS NOT WORKERS COMPENSATION INSURANCE."[2]

36. The Certificate also states that "[n]o benefits are payable under this Certificate for

[2] Exhibit "1," pp. 1, 3, 4.

any loss for which [y]ou may claim benefits as an employee under any workers' compensation, occupational disease or similar law."[3]

37. The "General Provisions" of the Certificate declare it to be a fully integrated agreement:

> **GENERAL PROVISIONS**
>
> **Entire Contract:** This Certificate (including any endorsements, riders or amendments), constitute the entire contract between the parties. Any statement made by You in the Application shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any Covered Person whose eligibility has been accepted by Us shall void the insurance or reduce the benefits under this Certificate or be used in defense to a claim hereunder in the absence of fraud.
>
> **Changes:** To be valid, any change or waiver must be in writing. It must be signed by our President or Secretary and be attached to this Certificate. No agent has authority to change or waive any part of this Certificate.

Exhibit "1," p. 21.

38. In relevant part, the Certificate also contains the following provision:

> **Right of Recovery/ Subrogation**
>
> You must refund to Us any overpayment of benefits that occurs because a third party was liable to pay certain of Your expenses due to a wrongful act, negligence or omission. The refund will equal the amount We paid under this Certificate. If the refund is due from another person or organization, You must help Us obtain the refund. Our right to be reimbursed has priority over Your right to be made whole. This means that Our right of recovery applies even if Your entire loss has not been compensated. However, the amount of Our recovery will be reduced by a proper share of Your legal fees and Your expenses needed to obtain the refund.
>
> We have the right to pursue a refund or recovery even if You do not do so. This is called subrogation. You must help Us use this right when requested. Our right of subrogation applies even if Your entire loss has not been compensated.

Exhibit "1," p. 22.

39. The Certificate further provides:

[3] Id., p. 19.

> **Conformity With State Law**
>
> Any provision of this Certificate which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Exhibit "1," p. 23.

C. PENNSYLVANIA'S ANTI-SUBROGATION REGIME

40. Effective since October 1, 1984, the Motor Vehicle Financial Responsibility Law ("MVFRL"), 75 Pa.C.S. § 1701 et seq., "is a comprehensive legislation that imposes mandatory obligations applicable to all automobile insurance providers in Pennsylvania."[4]

41. "The MVFRL was enacted as a means of insurance reform to reduce the escalating costs of purchasing motor vehicle insurance in our Commonwealth."[5]

42. It "is construed liberally to afford the greatest possible coverage to injured claimants."[6]

43. At the time of its enactment, Section 1720 of the MVFRL provided:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be **no right of subrogation** or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under [S]ection 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under [S]ection 1719 (relating to coordination of benefits).[7]

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[4] Mid-Century Insurance Co. v. Werley, 114 F.4th 200, 203 (3rd Cir. 2024)(cleaned up).

[5] Danko v. Erie Insurance Exchange, 630 A.2d 1219, 1222 (Pa. Super. 1993); see also Burstein v. Prudential Property and Casualty Ins. Co., 809 A.2d 204, 207 (Pa. 2002); Paylor v. Hartford Ins. Co., 640 A.2d 1234, 1235 (Pa. 1994).

[6] Danko, 630 A.2d at 1222.

[7] 75 Pa.C.S. § 1720(emphasis added).

44. The expansive language of Section 1720 attempted to preclude subrogation for "all potential benefits which may have been too numerous to mention."[8]

45. In 1990, the U.S. Supreme Court found that that Section 1720 was pre-empted by the Federal Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq., with regard to payments made under self-insured health plans.[9]

46. In 1993, the legislature repealed certain sections of the MVFRL, including the provisions of Section 1720 related to workers' compensation benefits, thereby "reinstat[ing] an employer's right of subrogation with respect to workers' compensation benefits in actions arising out of motor vehicle accidents, which had previously existed . . . prior to the MVFRL's enactment."[10]

47. In 2006, the Pennsylvania Supreme Court exempted payments made by a health maintenance organization ("HMO") on behalf of its member from the purview of Section 1720.[11]

48. Effectively then, other than for payments made under an ERISA health plan, a workers' compensation policy, or an HMO membership agreement, for over thirty years now, Section 1720 has prohibited subrogation against any recovery for injuries sustained a motor vehicle collision.[12]

49. This is consistent with the overall purpose of the MVFRL.

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[8] Fulmer v. Commonwealth, 647 A.2d 616, 619 (Pa. Cmwlth. 1994).

[9] See FMC Corp. v. Holiday, 498 U.S. 52 (1990).

[10] Oliver v. City of Pittsburgh, 11 A.3d 960, 962 (Pa. 2011).

[11] See Wirth v. Aetna U.S. Healthcare, 904 A.2d 858 (Pa. 2006).

[12] See, e.g., Alpini v. Workers' Compensation Appeals Board, 294 A.3d 307 (Pa. 2023)(holding that an employer had no subrogation claim for salary paid to an injured employee under a Pennsylvania statute that replaced workers' compensation benefits for public employees).

50. Specifically, by disallowing subrogation, Section 1720 precludes "boarding" – a practice that inflates damages in personal injury lawsuits.

51. Thereby, Section 1720 decreases the overall financial exposure of automobile insurers, which keeps the cost of automobile insurance lower.[13]

D. DEFENDANTS' WRONGFUL CONDUCT

52. Plaintiff was injured in a motor vehicle accident.

53. USFIC then paid various medical providers on account of Plaintiff's injuries and made payments to Plaintiff for his lost income.

54. These payments were not made under an ERISA health plan, a workers' compensation policy, or an HMO membership agreement.[14]

55. Nonetheless, USFIC, through Blue Star Claims, is attempting to unlawfully subrogate Plaintiff's recovery and receive payment for anything USFIC paid out on account of Plaintiff's injuries that were sustained in a motor vehicle accident.

56. The MVFRL explicitly forbids anyone to seek such reimbursement from the proceeds that Plaintiff may obtain with regard to his motor vehicle accident.

57. Therefore, the written notices sent by Blue Star Claims, on behalf of USFIC, that demand payments are unlawful, false, and misleading.

58. Hence, the actions of Blue Star Claims and USFIC (collectively, "Defendants") clearly violate the MVFRL, as well as the applicable regulations of the Unfair Insurance Practices, 31 Pa. Code § 146.1 et seq.; specifically, those pertaining to "Misrepresentation of policy

[13] See Burstein, supra; Paylor, supra.

[14] See, e.g., Atlantic Specialty Insurance Company v. Newson, 672 F.Supp.3d 1346, 1349-50 (N.D.Ga. 2023)(acknowledging that an "occupational accident" insurance policy is not a workers' compensation policy).

provision:"

a. "An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented;" and

b. "An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim."[15]

59. Other jurisdictions also restrict subrogation with regard to motor vehicle accidents.

60. Indeed, along with Pennsylvania, the states of Arizona, Connecticut, Georgia, Kansas, Missouri, New York, New Jersey, North Carolina, and Virginia do not allow subrogation under any circumstances (collectively, the "Non-subrogation States").

61. Given that Blue Star Claims asserts that it "has been in business since 2004 specializing in Occupational Accident claims and Workers' Compensation oversight,"[16] there is little doubt that Defendants were (or should have been) aware that they have no right to subrogate in the circumstances at issue.

62. Upon information and belief, Defendants have no procedures to restrict their subrogation efforts and to avoid violation of applicable laws.

63. Upon information and belief, Defendants systematically and as a matter of practice ignore the anti-subrogation statutes, enactments, and rulings.

64. Upon information and belief, Defendants systematically and as a matter of practice

[15] 31 Pa. Code § 146.4(a), (b).

[16] https://www.bluestarclaims.com/about-us/ (last visited on September 23, 2025).

make hundreds (if not thousands) of unlawful demands for subrogation.

65. Plaintiff avers that Defendants' conduct, as described herein, was not limited to the circumstances described herein, but was, and is, habitual, systematic, ongoing, and unrelenting in Defendants' business model and practice.

66. Plaintiff avers that the purpose of Defendants' behavior described herein (as well as their day-to-day business operation) is to obtain additional revenue and profit for Defendants' business enterprise.

67. Plaintiff and members of the Class(es) have been (and will continue to be) financially damaged due to Defendants' conduct, as set forth herein.

68. Plaintiff and members of the Class(es) have suffered and will continue to suffer actual damages due to Defendants' conduct, as set forth herein.

69. Plaintiff further states that Defendants' practices continue unabated and will continue well beyond the end of this case, for which Defendants have and/or will reap hundreds of thousands of dollars in unearned ill-gotten gains that they have no right to.

E. CLASS ACTION ALLEGATIONS

70. Plaintiff brings this action on behalf of himself and class(es) of similarly-situated individuals pursuant to Fed. R. Civ. P. 23.

71. Plaintiff brings this action as a class action for Defendants' unlawful efforts to collect funds for which they are not legally entitled.

72. Specifically, Plaintiff brings this action as a nationwide class action pursuant to Fed.R.Civ.P.23(b)(2) defined as:

> All natural persons who worked as independent contractor delivery drivers in a Non-subrogation State and have coverage offered and/or administered by Defendants under the Certificate ("Injunctive Class").

73. In addition, Plaintiff brings this action as a nationwide class action pursuant to Fed.R.Civ.P.23(b)(3) defined as:

> All natural persons who worked as independent contractor delivery drivers in a Non-subrogation State and have coverage offered and/or administered by Defendants under the Certificate for whom Defendants sought reimbursement of funds paid by one or more of the Defendants during the statutory period covered by this Complaint ("Declarative Class").

74. Finally, Plaintiff brings this action as a Pennsylvania state-wide class action pursuant to Fed.R.Civ.P.23(b)(3) defined as:

> All natural persons who worked as independent contractor delivery drivers in the Commonwealth of Pennsylvania and have coverage offered and/or administered by Defendants under the Certificate for whom Defendants sought reimbursement of funds paid by one or more of the Defendants during the statutory period covered by this Complaint ("PA Class").

75. The Injunctive Class, Declarative Class, and PA Class are collectively referred to herein as the "Classes."

76. The number of individuals in the respective Classes are so numerous that joinder of all members is impracticable. The exact number of members of the Classes can be determined by reviewing Defendants' records. Plaintiff is informed and believes and thereon alleges that there are over a hundred individuals in each of the defined Classes.

77. Plaintiff will fairly and adequately protect the interests of the Classes and has retained counsel that is experienced and competent in class action and insurance litigation.

78. Plaintiff has no interests that are contrary to, or in conflict with, members of the Classes.

79. Importantly, the Injunctive Class can be certified under Fed.R.Civ.P.23(b)(2), because Defendants have "acted or refused to act on grounds that apply generally to the class"

with respect to Defendants' assertion that they can seek subrogation under the terms of the Certificate.

80. Accordingly, "final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed.R.Civ.P.23(b)(2).

81. With respect to the Declarative Class and PA Class, a class action suit, such as the instant one, is superior to other available means for fair and efficient adjudication of this lawsuit. The damages suffered by individual members of the Classes may be relatively small when compared to the expense and burden of litigation, making it virtually impossible for members of the Classes to individually seek redress for the wrongs done to them.

82. A class action is, therefore, superior to other available methods for the fair and efficient adjudication of the controversy. Absent these actions, members of the Classes likely will not obtain redress of their injuries, and Defendants will retain the proceeds of their unlawful actions.

83. Furthermore, even if any member of the Classes could afford individual litigation against Defendants, it would be unduly burdensome to the judicial system. Concentrating this litigation in one forum will promote judicial economy and parity among the claims of individual members of the Classes and provide for judicial consistency.

84. There is a well-defined community of interest in the questions of law and fact affecting the Classes as a whole. The questions of law and fact common to each of the Classes predominate over any questions affecting solely individual members of the action. Among the common questions of law and fact are:

a. Whether Defendants ignored and/or misrepresented the applicable provisions of the insurance policy at issue;

b. Whether Defendants ignored and/or misrepresented the applicable law on the issue of subrogation;

a. Whether Defendants are prohibited from seeking to subrogate any amounts at issue in this case; and

b. Whether Plaintiff and the members of the Classes have sustained damages and, if so, the proper measure of damages.

85. Plaintiff's claims are typical of the claims of members of the Classes.

86. Plaintiff and members of the Classes have sustained damages arising out the same wrongful and uniform practices of Defendants.

87. Plaintiff knows of no difficulty that will be encountered in the management of this litigation that would preclude its continued maintenance.

F. CAUSES OF ACTION

COUNT I
Declaratory Judgment Action
(On Behalf of the Injunctive Class)

88. Plaintiff hereby incorporates all facts and allegations of this pleading by reference, as if fully set forth at length herein, and asserts this cause of action in the alternative to others.

89. An actual controversy exists between Plaintiff and Defendants herein in that, while Defendants are expected to deny such allegations, Plaintiff assert that:

a. Defendants' attempts to subrogate are contrary to the MVFRL and overall public policy of the Commonwealth;

b. Defendants' attempts to subrogate are contrary to the laws of the Non-subrogation States' laws, enactments, rulings, and overall public policy;

c. Defendants' attempts to subrogate are unlawful; and

d. Defendants' actions wrongfully interfere with Plaintiff's rightful possession, use, and enjoyment of his proceeds.

90. Plaintiff requests that a judicial determination and declaration be made that would set forth the parties' rights and obligations, as necessary and appropriate, to avoid a multiplicity of actions and in order for the respective parties to ascertain their rights and obligations with respect to the funds at issue.

COUNT II
Breach of Contract
(On Behalf of the Declarative Class)

91. Plaintiff hereby incorporates all facts and allegations of this document by reference, as if fully set forth at length herein, and asserts this cause of action in the alternative to others.

92. Defendants entered into a binding and enforceable contract, pursuant to which Defendants agreed to issue payments on Plaintiff's and the Declarative Class's behalf.

93. The terms of the parties' written agreement require Defendants to conform their actions to applicable state law. These terms of the contracts are uniform across the Declarative Class.

94. Defendants have failed to do so, since, in violation of state law, Defendants sought reimbursement of payments they issued on Plaintiff's and the Declarative Class's behalf.

95. These actions require Plaintiff and members of the Declarative Class to pay Defendants and/or escrow funds Defendants have claimed to be owed, which unlawfully restricts Plaintiff's and the Declarative Class's rights to their money and delay the resolution of their claim for damages.

96. Therefore, Defendants are in breach of the parties' agreement.

COUNT III
Conversion
(On Behalf of the Declarative Class)

97. Plaintiff hereby incorporates all facts and allegations of this pleading by reference, as if fully set forth at length herein, and asserts this cause of action in the alternative to others.

98. By demanding that Plaintiff and members of the Declarative Class pay Defendants and/or escrow funds Defendants have claimed to be owed, Defendants wrongfully exerted dominion over Plaintiff and members of the Declarative Class's funds, denying them rights thereto and, thereby, delaying the timely resolution of their claims.

99. These actions are unlawful, because Defendants have no right to said funds.

100. The foregoing conduct of Defendants constitutes an unlawful conversion of Plaintiff's and members of the Declarative Class's money.

COUNT IV
Bad Faith
(On Behalf of the PA Class)

101. Plaintiff hereby incorporates all facts and allegations of this pleading by reference, as if fully set forth at length herein, and asserts this cause of action in the alternative to others.

102. Section 8371 of the MVFRL, 42 Pa.C.S. § 8371, entitled "Actions on insurance policies," provides:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
>
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
>
> (2) Award punitive damages against the insurer.
>
> (3) Assess court costs and attorney fees against the insurer.

103. An insurer violates this statute when it fails to "accord the interest of its insured the same faithful consideration it gives its own interest."[17]

104. For instance, "bad faith" exists where the insurer does not properly investigate the underlying circumstances of the loss, misrepresents the benefits or coverages available under an insurance policy, or acts in a manner that delays a timely resolution of a claim.[18]

105. Ultimately, to prevail on a claim pursuant to Section 8371, a plaintiff must demonstrate that: (a) there was no reasonable basis for the insurer's behavior; and (b) the insurer knew or recklessly disregarded the fact that it was acting in an unreasonable manner.[19]

106. Section 8371 unequivocally applies to automobile insurance policies.[20]

107. Defendants through their representatives, agents, and/or employees have breached their duties to act in good faith by, *inter alia*:

a. Ignoring the applicable law on the issue of subrogation, including, the MVFRL;

b. Ignoring the applicable provisions of the insurance policy at issue;

c. Misrepresenting the applicable law on the issue of subrogation, including the MVFRL;

d. Misrepresenting the applicable provisions of the insurance policy at issue;

e. Making unlawful demands for payment of amounts that they were never

[17] Cowden v. Aetna Cas. & Sur. Co., 134 A.2d 223, 228 (Pa. 1957).

[18] See, e.g., Hollock v. Erie Ins. Exchange, 842 A.2d 409 (Pa. Super. 2004); O'Donnell v. Allstate Insurance Co., 734 A.2d 901 (Pa. Super. 1999).

[19] See Rancosky v. Washington National Insurance Co., 170 A.3d 364 (Pa. 2017).

[20] See, e.g., Brown v. Progressive Insurance Co., 860 A.2d 493 (Pa. Super. 2004).

entitled to; and/or

f. Preventing timely resolution of insurance claims.

108. Given their alleged experience in handling and oversight of work-related insurance claims, there is little doubt that Defendants were (or should have been) aware that the applicable laws prohibited subrogation under the circumstances at issue.

109. Regardless, it has long been recognized that ignorance of the law is never an excuse.[21]

110. Because of Defendants' unlawful behavior, they obtained additional revenue and profit that they were otherwise not entitled to.

111. In short, Defendants unequivocally placed their own self-interest above those of their insured.

112. Defendants' actions constitute willful and/or outrageous conduct towards their insured.

113. For the reasons set forth above, Defendants violated Section 8371.

114. Therefore, Defendants are liable for statutory interest, punitive damages, attorneys' fees, and costs to Plaintiff and the PA Class.

V. CLAIM FOR RELIEF

WHEREFORE, Plaintiff respectfully prays for:

(a) Designation of this action as a class action pursuant to Fed. R. Civ. P. 23;

(b) Designation of Plaintiff as representative of the Injunctive Class;

(c) Designation of Plaintiff as representative of the Declarative Class and PA

[21] See, e.g., Faudel v. Phoenix Insurance Co., 1818 WL 2111 *40 (Pa. 1818)(declaring – "Let it be understood that ignorance of the law can form no excuses for the assured, because all who trade to any country take upon the knowledge of the laws of that country. . . .").

Class;

(d) Designation of Plaintiff's counsel as class counsel for the Classes;

(e) A Declaration that Defendants have sought to unlawfully seek subrogation when it is prohibited by law;

(f) An Order enjoining Defendants from any further violations of the law;

(g) Actual damages;

(h) Interest;

(i) Punitive damages;

(j) Attorneys' fees and costs; and

(k) Such other relief as the Honorable Court shall deem just and appropriate.

VI. DEMAND FOR JURY TRIAL

Plaintiff demands a trial by jury as to all issues so triable.

(SIGNATURES ON THE FOLLOWING PAGE)

Date: September 23, 2025

Respectfully submitted,
KALIKHMAN & RAYZ, LLC

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Counsel for Plaintiff(s) and the Proposed Classes

EXHIBIT 1

UNITED STATES FIRE INSURANCE COMPANY
(Called "We, "Our", or "Us")
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET OCCUPATIONAL ACCIDENT CERTIFICATE

This Certificate of Insurance is issued under the terms of the Master Group Policy issued to the Policyholder. We will pay the benefits described in this Certificate to a Covered Person for certain losses resulting directly and independently of all other causes from an Injury sustained in an Occupational Accident that occurs while this Certificate is in force and coverage under the Master Group Policy is in effect. Coverage is subject to all the provisions, conditions, exclusions and limitations described in this Certificate. Coverage takes effect at 12:01 A.M. on the Effective Date shown on the Schedule of Benefits.

SIGNED FOR **THE UNITED STATES FIRE INSURANCE COMPANY** BY:

Signature

Marc J. Adee
Chairman and CEO

Signature

Michael P. McTigue
Secretary

IMPORTANT NOTICE

THIS IS A CERTIFICATE FOR OCCUPATIONAL ACCIDENT BENEFITS ONLY. BENEFITS ARE NOT PAID FOR SICKNESS OR ANY OTHER TYPE OF INJURY. THIS IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.

Renewal: Subject to Our consent, Your coverage may be renewed on each Anniversary Date. We have the right to refuse to renew coverage on any Anniversary Date. If we refuse to renew coverage under this Certificate, We will provide at least 31 days advanced written or authorized electronic or telephonic notice of Our intent to not renew.

Cancellation: Either You or We may end this Certificate at any time by providing the other party with written, or authorized electronic, notice. If We end this Certificate, it will be effective on the latter of: 1) the date stated in the notice; or 2) 10 days after We deliver the notice. If You end this Certificate, it will be effective on the latter of: 1) the date We receive the notice; or 2) the date stated in the notice.

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Policyholder: DoorDash, Inc.

Policy Number: US2070792

Insured Class: All Independent Contractors not domiciled in California performing Covered Activities for DoorDash, Inc.

Certificate Effective Date: 9/1/2023

Anniversary Date: 9/1/2025

Premium Due Date: The 15th of each month

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Time Limit For Loss: 365 days from date of the Occupational Accident

Death Benefit: $200,000

Dismemberment Principal Sum: $200,000

DISABILITY INCOME BENEFIT

Weekly Benefit

Temporary Total Disability – 50% of Average Weekly Earnings, subject to the following:

Minimum Amount per Week: $100

Maximum Amount per Week: $500 minus Other Income Benefits.

Monthly Benefit

Continuous Total Disability - 4.3 times Average Weekly Earnings multiplied by 0.50, subject to the following:

Maximum Amount per Month: $2,150 minus Other Income Benefits.
Maximum Payment Period is 5 years or to age 70.

Elimination Period

Temporary Total Disability: 7 days of continuous Total Disability

Continuous Total Disability: 104 weeks of continuous Total Disability

Maximum Payment Period

Temporary Total Disability- 104 weeks
Continuous Total Disability- 60 months to Age 70

ACCIDENT MEDICAL/DENTAL EXPENSE BENEFITS

Maximum Benefit

$1,000,000 per Occupational Accident

Time Limit for Loss

Treatment must begin within 90 days from the date of an Injury.

Maximum Payment Period

104 weeks from the date of the Injury.

DEFINITIONS

Certificate

This document, which is a legal contract between You and Us to provide coverage for Occupational Accidents.

Company

United States Fire Insurance Company, also referred to as We, Us and Our.

Covered Activity

Covered Activities are the following:

The time period:

a. beginning when a Covered Person accepts a request through the Policyholder's platform, and is on route to the first requested pick-up location;
b. continuing while the Covered Person transports goods; and
c. ending at the later of:
    i. when the goods have been delivered;
    ii. when the request is cancelled (and such cancellation is notified to the Covered Person) with no further action required by the Covered Person; or when the goods have been returned to the merchant by the Covered Person due to the cancellation of the request which required further action by the Covered Person.

Covered Activities do not include Engaged Time on one or more other Network Company's applications or platforms (other than the Policyholder's application or platform).

Covered Activities do not include Personal Activities.

Covered Person

An Eligible Person, as described in this Certificate, for whom premium is paid, but only while he or she is performing a Covered Activity.

Cumulative Trauma

An Injury diagnosed by a Physician as occurring without sudden cause or result. Cumulative Trauma includes Injury caused by continual stress and strain. Such Injury may be causally related to Your job. Such Injury may be due to repetitive traumatic acts.

Delivery Network Company ("DNC")

A business entity that (1) maintains an online-enabled application or platform used to facilitate delivery services on an on-demand basis, and (2) maintains a record of the amount of engaged time and engaged miles accumulated by DNC couriers. Deliveries are facilitated on an on-demand basis if DNC couriers are provided with the option to accept or decline each delivery request and the DNC does not require the DNC courier to accept any specific delivery request as a condition of maintaining access to the DNC's online-enabled application or platform.

Designated Contract

An agreement between the Covered Person and the Policyholder, in which the Covered Person agrees to perform certain specified activities for compensation.

Engaged Time

Subject to the conditions set forth below, the period of time, as recorded in a Network Company's online-enabled application or platform, from when an app-based driver accepts a rideshare request or delivery request to when the app-based driver completes that rideshare request or delivery request. Engaged time shall not include:

(A) any time spent performing a rideshare service or delivery service after the request has been cancelled by the customer; or
(B) any time spent on a rideshare service or delivery service where the app-based driver abandons performance of the service prior to completion.

Health Care Plan

Any plan providing medical expense benefits by:
1. Any type of service plan contract,
   Any group or blanket insurance, independent contractor benefit plan, or
   Any plan arranged through an employer, trustee, union or independent contractor benefit association, or
   Any individual plan whether this plan is Your plan or You are covered under Your spouse's plan;
2. Medicare; or
3. Any plan or program created or administered by the federal or state government or their agencies, with the exception of Medicaid.

Health Care Provider

A person who provides health care services, who practices within the scope of his or her license and is licensed in the United States, its possessions or the countries of Canada and Mexico.

Hospital

An acute care, general hospital, which:

1. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;

2. has organized departments of medicine and major surgery;

3. has a requirement that every patient must be under the care of a physician or dentist;

4. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);

5. is duly licensed by the agency responsible for licensing such Hospitals; and

6. is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Immediate Family

Means Your: wife or husband; domestic partner, in-laws; brother or sister; step-brother or step-sister; parent or step-parent; or child. It also means any person living with You.

Independent Contractor

While coverage is in effect, any Covered Person who contracts with the Policyholder to perform work and who is not an employee of the Policyholder.

Injury

Means bodily harm which results directly and independently of disease or bodily infirmity from an Occupational Accident. All Injuries to the same Covered Person sustained in one Occupational Accident (including all related conditions and recurring symptoms of the Injuries) will be considered one Injury.

Inpatient

A Covered Person:

1. who is confined in a Hospital as a registered bed patient; and
2. for whom at least one day's Room and Board is charged by the Hospital.

Master Policy (or Policy or Master Group Policy)

A legal contract between the Policyholder and Us, describing the terms and conditions of this coverage subject to its provisions, limitations, and exclusions.

Member of the Insured Class

While coverage is in effect, any Independent Contractor performing Covered Activities for the Policyholder for whom coverage under this Certificate has been purchased by the Policyholder.

Minimum Weekly Benefit

The minimum weekly Disability Income Benefit amount payable while the Covered Person is Totally Disabled.

Network Company

A business entity that is a DNC and/or a TNC.

Occupational Accident

A sudden, unforeseen external event or series of events, which occur while coverage is in effect, that are work related and that result in bodily Injury within 72 hours of the date of the event.

Suicide, self-destruction, attempted-self-destruction or intentional self-inflicted Injury while sane or insane is not considered an Occupational Accident. An event caused by 1.) voluntarily inhaling gas, 2.) voluntarily taking any drugs or narcotics, 3.) being intoxicated or under the influence of alcohol or illegal drugs, or 4.) taking medicine that not taken at the dosage or for the purpose that is not as prescribed by the Covered Person's Physician is not considered to be an Occupational Accident.

This event must meet all of the following:
1. It must happen while You are engaging in a Covered Activity as defined in this Certificate.
2. It must happen while You are covered under this Certificate.
3. The bodily Injury must result directly from the Occupational Accident and not be the result of any other cause.

"Occupational Accident" **does not** include any of the following:
1. Willful criminal activity.
2. Hernia of any type, unless specifically covered as shown in the Schedule of Benefits of this Certificate.
3. Hemorrhoids, unless specifically covered as shown in the Schedule of Benefits of this Certificate.
4. Suicide or attempted suicide.
5. Cumulative Trauma, unless specifically covered as shown in the Schedule of Benefits of this Certificate.
6. Occupational Disease, unless specifically covered as shown in the Schedule of Benefits of this Certificate.
7. Illegal Occupation or Criminal Activity. We are not liable for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation or other willful criminal activity. As used here:
   (a) "Willful criminal activity" includes, but is not limited to, any of the following:
   (i) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.
   (ii) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.
   (b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

Occupational Disease

A disease that:
1. Is not traceable to a specific Occupational Accident; and
2. Is caused by exposure to a disease producing agent present in Your occupational environment.

Online

The time when You are utilizing a Network Company's online-enabled application or platform and can receive requests for rideshare services or delivery services from a Network Company, or during Engaged Time.

Other Occupational Accident Policy

Any other insurance policy (group or individual) that provides benefits payable to You or Your beneficiaries for any medical, disability, dismemberment or death relating to an occupational accident that is offered by or provided by a Network Company other than the Policyholder.

Personal Activity

An activity that is not reasonably related to the Covered Person's activities as an Independent Contractor subject to the Designated Contract with the Policyholder.

Physician

A person who:
1. is a legally qualified-practitioner of the healing arts and is licensed in the United States, its possessions or the countries of Canada and Mexico;
2. practices within the scope of his or her license;
3. is not the Covered Person;
4. is not related to the Covered Person as Immediate Family.

Policyholder

The entity, shown in the Schedule of Benefits, to which the Master Policy has been issued.

Reasonable Charges

An amount measured and determined by Us by comparing the actual charge for the service or supply with the prevailing charges made for it. It takes into account all pertinent factors including:

1. The complexity of the service.
2. The range of services provided.
3. The prevailing charge levels in the geographic area where the provider is located and other geographic areas having similar medical cost experience.
4. OWCP Workers Compensation Approved Fee Schedule.

Return to Work

The date a Physician releases You to begin working again at full duty and without restriction.

Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by a Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Schedule of Benefits

A section of this Certificate summarizing the coverage and benefits provided.

Total Disability

Your inability to perform all of the substantial and material duties of Your regular employment or occupation.

If Your Total Disability continues for more than 104 weeks, You must meet both of the following requirements as well:

1. You cannot be engaged in any work for pay or profit.
2. You must be unable to perform all the substantial and material duties of **any** occupation or employment that You are qualified for by reason of education, training or experience.

Transportation Network Company ("TNC")

An organization, including, but not limited to, a corporation, limited liability company, partnership, sole proprietor, or any other entity that provides prearranged transportation services for compensation using an online-enabled application or platform to connect passengers with drivers using a personal vehicle.

We, Our, Us

United States Fire Insurance Company, underwriting this insurance, or its authorized agent.

You, Your, Yours

The Covered Person, who meets the eligibility requirements of this Certificate and whose insurance under the Master Group Policy is in force.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Eligible Person:

Independent Contractor

Who Is Eligible For Coverage

Each person who is an Eligible Person.

Coverage is provided to a person who is an Eligible Person under this Certificate **only** under the following circumstances:

1. The Eligible Person, or someone on behalf of an Eligible Person, has submitted an Application, which has been accepted by Us;
2. The Master Policy is in effect;
3. The Eligible Person is a party to a Designated Contract with the Policyholder;
4. The Eligible Person is performing a Covered Activity described; and
5. The Eligible Person is not performing a Personal Activity described.

We maintain the right to investigate eligibility status and dispatch records to verify that eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

When Coverage Starts

Coverage under this Certificate starts only after an Application is filed with and approved by Us or our authorized agent and the required premium for coverage is paid on behalf of You, to Us or our authorized agent.

Coverage goes into effect on the latest of:

1. This Certificate Effective Date shown in the Schedule of Benefits;
2. The date You are included as an Eligible Person;
3. The date We, or our authorized agent, receive the completed Application; or
4. The date the required premium is received by Us or our authorized agent.

If You are not working because You are disabled on the date coverage would start, coverage will not start until You are no longer disabled and return to work.

WHEN COVERAGE IS IN EFFECT

After coverage starts, coverage shall be in effect for a Covered Person when:

1. The Covered Person is Online and is utilizing the Policyholder's online-enabled application or platform;
2. The Covered Person is not in Engaged Time on one or more other Network Company's application or platforms (other than the Policyholder's application or platform); and
3. The Covered Person is not engaging in Personal Activities.

Claims Covered by this Certificate and any Other Occupational Accident Policy

A Covered Person can be Online and utilizing multiple Network Company's' online-enable applications or platforms simultaneously. However, notwithstanding any provision to the contrary, if a loss is covered by the Certificate and is also covered by an Other Occupational Accident Policy, We are entitled to contribution from the Other Occupational Accident Policy for the pro-rata share of coverage attributable to one or more other Network Companies. However, in no circumstances will the combined amount paid by the Certificate and any Other Occupational Accident Policy exceed the maximum benefit amounts, limits, and Principal Sums described in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

When Coverage Stops

Coverage will stop on the earliest of:
1. The date You are no longer an Eligible Person;
2. The end of the period for which You, or someone on Your behalf, paid premiums;
3. The date the coverage under this Certificate ends;
4. The date the Policyholder's coverage ends;
5. The date the Master Policy ends.

When Your coverage ends it will not affect a claim for a covered loss due to an Occupational Accident that happened while the coverage was in effect.

SUSPENSION OF COVERAGE DURING MILITARY SERVICE

If You enter into full-time duty in the United States military or naval services, or the armed forces reserve, including the National Guard, You may request coverage be suspended as of the first date of active duty status and through the period of such duty. The request must be in writing. The suspension will be allowed for up to five years of continuous active duty. When We receive notification of Your active duty status, any required adjustment of premium will be made, including refund of any unearned premium for the suspension period.

During the time of Certificate suspension: it will not be in force and no premium needs to be paid by You. Upon active duty termination status, You may request coverage resumption without proof of insurability. This request must:
- be in writing;
- be submitted within 60 days of Your termination from active duty status; and
- include the required premium.

Coverage will be retroactive to the date of the active duty termination. This Certificate will not cover any loss which results from or which first manifests itself during the time of active duty, and which the Secretary of Veteran's Affairs has determined is a condition incurred in the line of duty. All other rights under this Certificate remain the same as before.

Any Elimination Period not completed prior to coverage suspension must be completed following resumption of coverage. However, in no event will the sum of time served for the Elimination Period prior to and following coverage suspension exceed the length of the original Elimination Period.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Death Benefit

If You die due to an Occupational Accident while covered under this Certificate, We will pay the Death Benefit shown in the Schedule of Benefits.

Your Death Benefit, in all cases, shall be paid in installments in the same manner and amounts as the Disability Income Benefit would have to be made to You. However, no payment shall be made at a weekly rate of less than $224.

This benefit shall be paid to Your Eligible Dependents

Dismemberment Benefit

If You have an Occupational Accident while covered under this Certificate, We will pay the Percent of the Dismemberment Principal Sum shown below for the Covered Loss named below. To be covered the loss must meet all of the following requirements:

1. The loss must be the direct result of an Injury sustained in an Occupational Accident.
2. The Occupational Accident must occur while You are covered under this Certificate.
3. The loss must occur within the Time Limit shown in the Schedule of Benefits.

The Principal Sum is shown in the Schedule of Benefits.

Standard Dismemberment Benefits Chart

Covered Loss	Percent of Dismemberment Principal Sum
Both Hands, Both Feet, or Sight in Both Eyes	100%
Any combination of Foot, Hand or Sight in One Eye	100%
Speech and Hearing in Both Ears	100%
Use of Both Arms and Both Legs	100%
Use of Both Arms or Both Legs	75%
Use of One Arm and One Leg on One Side of the Body	50%
One Hand, One Foot or Sight in One Eye	50%
Thumb and Index Finger of Same Hand	25%

Standard Benefits Chart Non-Duplication Limitation

Only one benefit, the highest, will be paid if you suffer more than one Covered Loss described on the Standard Dismemberment Benefits Chart for an Occupational Accident.

Loss of hand or foot means the complete Severance through or above the wrist or ankle joint

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total, permanent and irrecoverable loss of audible communication.

Loss of Thumb and Index Finger means complete severance through or above the

metacarpophalangeal joints (the joints between the fingers and the hand).

Loss of Use means complete paralysis of the entire limb that cannot be recovered. A Physician must determine the Loss of Use to be complete and not reversible at the time the claim is submitted.

Severance means the complete separation and dismemberment of the part from the body.

Benefit Specific Exclusions

No payment will be made for any loss caused or contributed to by the following:

1. Disease, bodily or mental infirmity, functional nervous or emotional disorders, with or without a demonstrable organic cause, or any medical or surgical treatment, or diagnostic procedures for any of these, or for any condition or treatment that is not the direct result of an Injury sustained in a covered Occupational Accident.

2. Ptomaine or bacterial infection, other than pyogenic or bacterial infection occurring as a consequence of an accidental cut or wound sustained in an Occupational Accident.

3. No Dismemberment Benefit is payable if a Death Benefit is payable for an Injury sustained in the same covered Occupational Accident.

Other exclusions that apply to this benefit are in **General Exclusions.**

DISABILITY INCOME BENEFIT

If You become Totally Disabled due to an Injury sustained in an Occupational Accident that happens while covered under this Certificate, You will be paid the benefits described below.

You must satisfy the Elimination Period and be under the Appropriate Care of a Physician. You must provide Us with satisfactory proof of Your Total Disability, at Your expense, before benefits will be paid. We will require continued proof of Your Total Disability to be provided from time to time at Your expense for benefits to continue.

Temporary Total Disability Benefit

Payments will start as shown in the Schedule of Benefits. Payments will stop on the earliest of the following:

1. The date Your Total Disability stops.
2. The date You return to work.
3. When the Maximum Payment Period for Temporary Total Disability shown in the Schedule of Benefits is reached.
4. The date You reach the Age Limit shown in the Schedule of Benefits.

Continuous Total Disability Benefit

Provided Your disability satisfies the definition of Total Disability, payments will start on the later of:
1. The first day of the week after the Maximum Payment Period under Temporary Total Disability is reached.

2. The date You are granted a Social Security Disability Award for Your Total Disability solely due to the Occupational Accident for which a claim has been filed and for no other unrelated medical reasons.

Payments will stop on the earliest of the following:

1. The date Your Total Disability stops.
2. The date You return to work.
3. When the Maximum Payment Period for Continuous Total Disability shown in the Schedule of Benefits is reached.
4. The date You reach the Age Limit shown in the Schedule of Benefits.

MAXIMUM PAYMENT PERIODS

The Maximum Payment Periods shown in the Schedule of Benefits are for each period of disability.

SUCCESSIVE PERIODS OF DISABILITY

Once You are Totally Disabled under this Certificate, separate periods of Total Disability resulting from the same or related causes are a continuous period of Total Disability unless You return to work for at least 3 months between periods of Total Disability. Only one Elimination Period and Maximum Payment Period apply to any one period of continuous Total Disability.

A period of Total Disability is not continuous if separate periods of Total Disability result from unrelated causes, or Your later Total Disability occurs after Your coverage under this Certificate ends. This provision will not apply if You are eligible for coverage under a plan that replaces this Certificate.

No payment will be made for any Total Disability for which benefits are payable under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Appropriate Care - The determination of an accurate and medically supported diagnosis of Your Total Disability, and ongoing medical treatment and care of Your disability by a Physician that conforms to generally-accepted medical standards, including frequency of treatment and care.

Average Weekly Earnings - 100% of the average payments made to You by the Policyholder for performing Covered Activities. Average Weekly Earnings will not include any performance bonus, expense reimbursement or other extra or additional payments of any kind. Average Weekly Earnings will be determined as the average of such payments over the shorter of:

1. The 104 weeks immediately prior to the date Total Disability began; or
2 The period that the Covered Person performed Covered Activities on behalf of Policyholder.

Elimination Period - The period of time You must be continuously Totally Disabled before Disability Income Benefits are payable. Your Elimination Period is shown in the Schedule of Benefits.

Other Income Benefits -

Other Income Benefits include any amounts that You or Your dependents receive under:

1. Any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.

2. Any Social Security Disability Income benefits or Social Security retirement benefits You receive or any third party receives (or is assumed to receive) on Your behalf or for Your dependents; or, if applicable, that Your dependents receive (or are assumed to receive) because of Your entitlement to such benefits.
3. Any proceeds payable under any insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay our pro rata share of the total claim.

   "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.

4. The amounts received from any Social Security Disability Income Benefits, Social Security Retirement Benefits unless Social Security Retirement Benefits began prior to the date of the covered loss, Personal Auto policy or No-fault policy, Commercial Auto policy, Homeowners policy, General Liability policy, Other Occupational Accident Policy the amount received for lost wages or lost income in a lawsuit or in the settlement of a lawsuit, any individual or group disability benefits, or any other third party payable to You on account of such disability.

ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT

The Accident Medical/Dental Expense Benefit provides payment for the Covered Expenses shown below. These expenses must be charged to You while covered. These expenses must be for services or supplies ordered by a Physician as Medically Necessary for Injuries that result directly, and from no other causes, from an Occupational Accident. These benefits are subject to the Deductible, Coinsurance Rate, Maximum Payment Periods, and Maximum Benefits shown in the Schedule of Benefits (if any).

Maximum Benefit

The Maximum Benefit for any one Occupational Accident is shown in the Schedule of Benefits (if any).

Covered Expenses

Covered Expenses are the actual cost to You of the Reasonable Charges for the services and supplies listed below. The service or supply must be:
1. Ordered by a Physician for the diagnosis or treatment of an Occupational Accident.
2. Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We, at our discretion, may consider the cost of that alternative to be Covered Expenses. In this case, Covered Expenses are limited to the Reasonable Charges for that diagnostic or treatment alternative.

We pay Covered Expenses:

1. After the Covered Person satisfies any deductible; and

2. We pay benefits without regard to any coordination of benefits provisions in any other insurance policy.

Covered Expenses include:

Ambulance Services

Transportation for a Medical Emergency
1. By professional ambulance, other than air ambulance, to and from a Hospital.

2. By regularly scheduled airline, railroad or air ambulance to the nearest Hospital qualified to give the required treatment.

Ambulance Services must be Medically Necessary.

These services must be given within the United States or Canada.

Ambulatory Surgical Center Charges

Medically Necessary charges for a center's services given on the day of a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Anesthetics and charges for giving them.

Dental Services

Coverage for dental services is limited to the following as the result of an Occupational Accident that happens while covered:
1. Appliances and splints placed on or attached to natural teeth.
2. Full or partial dentures.
3. Fixed bridgework if needed because of Injury to natural teeth.
4. Prompt repair to natural teeth if needed because of Injury to those teeth.

Health Care Provider's Services

Services of a licensed or certified Health Care Provider acting within the scope of that license or certification. Covered Expenses resulting from services provided by a Health Care Provider are payable on the same basis as Covered Expenses resulting from services provided by a Physician.

Hospital Charges

The daily room rate when You are confined in a Hospital, general nursing care provided and charged for by the Hospital, and ancillary Hospital expenses for services and supplies, including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) while You are confined in a Hospital.

Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

Medical Supplies

1. Prescribed drugs and medicines.
2. Surgical supplies (such as bandages and dressings).
3. An appliance that replaces a lost body organ or part or helps an impaired one to work.
   An appliance will be replaced only if it is damaged as the result of an Occupational Accident that happens while covered.
4. Oxygen and charges for giving it. This includes rental of required equipment.
5. Rental of a wheelchair or hospital-type bed.
6. Rental of a device to help breathing when paralyzed.

Nursing Services

Services of a trained nurse. In most cases, the services of a private duty nurse, while You are confined in a Hospital, are not Medically Necessary. In any case when such services are not deemed Medically Necessary, charges made by a private duty nurse will not be considered Covered Expenses. No benefits will be paid for such private duty nursing.

Occupational Therapy

Services for medical care and treatment by an occupational therapist practicing within the scope of his or her license.

Physician's Services

1. Medical Care and Treatment.
2. Hospital, office and home visits.
3. Emergency room treatment services.
4. Surgery.
5. Services for surgical procedures.
6. Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of:
   (a) surgery to treat an Injury that happens while You are covered under this Certificate.
   (b) Reconstructive surgery to remove scar tissue due to an Injury that happens while You are covered under this Certificate.

Assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge for the surgery.

If You undergo more than one surgical procedure performed during the same operative session, Covered Expenses for multiple surgical procedures are limited as follows:

1. For the second procedure, to 50% of the Covered Expenses for the secondary procedure.
2. For any subsequent procedure, to 25% of the Covered Expenses for the subsequent procedure.

Physiotherapy

When rendered by a Physician, as defined, for any form of the following: physical or mechanical therapy; diathermy; ultrasonic therapy; and heat treatment in any form. Coverage is limited to one visit per day.

Skilled Home Health Care

Services given by a Home Health Care Agency. The following items are covered to the extent that they would have been covered under this benefit if You had stayed in a Hospital.
1. Medical supplies.
2. Drugs and medications ordered by a Physician.
3. Laboratory services given or ordered by a Hospital.

The care has to be ordered in writing and supervised by a Physician.

Skilled Nursing Facility Charges

Room and Board and Other Services and Supplies. Charges will be counted as Covered Expenses up to the facility's regular daily charge for a semi-private room. The care has to be supervised by a Physician.

Speech Therapy

Speech therapy given to restore speech. The speech must have been lost or impaired due to an Injury that happens while You are covered under this Certificate.

Benefit Specific Exclusions

1. Services or supplies that are not Medically Necessary, including any confinement, treatment, service or supply given in connection with a service or supply that is not Medically Necessary.

2. Care of and treatment to the teeth and gums is not covered except for those services specifically named in this benefit.

3. Eye glasses, eye refractions and hearing aids, unless required by an Occupational Accident that happens while covered.

4. Injury caused by war or international armed conflict.

5. Services given by any of the following persons:
   (a) A member of Your Immediate Family.
   (b) Volunteers or persons who do not normally charge for their services.

6. Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.

7. Drugs, treatments, services or supplies that are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinement, treatment, service or supplies.

8. Cosmetic or reconstructive surgery or treatment (surgery or treatment primarily to change appearance) whether or not for psychological or emotional reasons. This exclusion does not apply to reconstructive surgery specifically named in this Certificate.

9. Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
   a. Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
   b. Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

   Care that meets one of the conditions above is custodial care regardless of any of the following:
   a. Who recommends, provides or directs the care.
   b. Where the care is provided.
   c. Whether or not the patient can be or is being trained to care for himself or herself.

10. Treatment in a United States government or agency hospital. However, the reasonable cost incurred by the United States for medical care and treatment for a non-service connected disability given to a veteran by the United States or one of its agencies is covered to the extent the care and treatment is otherwise covered under this Certificate.

11. Expenses for which You are not legally required to pay.

12. Charges made by a Hospital for room, board or other fees during a confinement in an area of the Hospital that is used as a special care area, by whatever name called. A special care area is any area of a Hospital that renders services on an in-patient basis for other than acute care of sick or injured persons. Benefits for a covered facility that is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

13. Private duty nursing services that are not Medically Necessary. In most cases, private duty nursing services provided while You are confined in a Hospital are not Medically Necessary.

Other exclusions that apply to this benefit are in **General Exclusions.**

Home Health Care Agency means

An agency or organization that is either:
1. Approved under Medicare.
2. Established and operated in accordance with the applicable licensing and other laws.

Medical Emergency means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medically Necessary means that a service or supply is Medically Necessary for the diagnosis and/or treatment of an Injury. This determination is made by Us and is based on and consistent with standards approved by Our medical personnel. These standards are developed, in part, with consideration to whether the service or supply meets the following:

1. It is appropriate and required for the diagnosis or treatment of the Injury.
2. It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
3. There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply given.

A determination that a service or supply is not Medically Necessary may apply to the entire service or supply or to any part of the service or supply.

Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Skilled Nursing Facility means an institution that fully meets one of the following tests:
1. It is approved by Medicare as a Skilled Nursing Facility.
2. If not approved by Medicare, the facility must be operated under the applicable licensing and other laws of the jurisdiction where it is located.

It cannot be, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, or a home for alcoholics or drug addicts or the mentally ill.

GENERAL EXCLUSIONS

In addition to the exclusions listed in specific benefit sections, this Certificate does not cover any loss:

1. Covered by any workers' compensation, employers' liability, occupational disease or similar law.

2. Engaging in any *ILLEGAL OCCUPATION OR CRIMINAL ACTIVITY.* We are not liable for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation or other willful criminal activity. As used in this section:
   (a) "Willful criminal activity" includes, but is not limited to, any of the following:

(i) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.
(ii) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.
(b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

3. Resulting from aviation.

4. Resulting from war or act of war; whether declared or not.

5. Resulting from duty in the armed forces of any country or international authority.

6. That is psychological or emotional in nature, including pain and suffering, that is not a direct result of an Occupational Accident.

7. Resulting from Cumulative Trauma (see Definitions), unless specifically shown as "Included" in the Schedule of Benefits.

8. Resulting from Occupational Disease (see Definitions), unless specifically shown as "Included" in the Schedule of Benefits.

9. By anyone who is an employee of the Policyholder.

NON-DUPLICATION OF WORKERS' COMPENSATION BENEFITS

No benefits are payable under this Certificate for any loss for which You claim benefits as an employee under any workers' compensation, occupational disease or similar law. If benefits have been started, they will be suspended upon notification. If You claim benefits under this Certificate and, at a later date, claim benefits for the same loss under any workers' compensation, occupational disease or similar law or benefit plan, We have the right to recover from You the amount of the benefits paid for such loss under this Certificate.

PREMIUM PROVISIONS

GRACE PERIOD:

A Grace Period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent in accordance with the Cancellation provision of Our intent to terminate coverage under this Certificate. Coverage will end if the premium is not paid by the end of the Grace Period. You shall be liable for the payment of the premium accruing for the period the Master Group Policy continues in force.

PREMIUMS:

The first Premium is due on the Effective Date of Contract. Coverage will not go into effect unless this first premium is paid in full by that date. After that, premiums will be due monthly in advance unless We agree to some other method of premium payment with You, or the person paying premium on Your behalf. Premiums are payable to Us or Our authorized agent by the Premium Due Date shown in the Schedule of Benefits.

If any premium is not paid when due, participation under this Certificate will be canceled as of the last day of the period for which premiums were paid, except as provided in the Grace Period provision.

CHANGES IN RATES:
The initial premium rates for insurance under this Certificate will be based on the schedule of premium rates agreed to by the Policyholder and Us. We may change rates from time to time with at least 31 days advanced written or authorized electronic or telephonic notice. We reserve the right to change rates at any time if any of the following events take place:

1. The terms of this Certificate change.
2. There is a change in the factors bearing on the risk assumed.
3. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

PREMIUM REFUND AT DEATH

If the Covered Person dies before the end of a Premium Period for which premium has been paid, We will refund the premium or the portion of the premium actually paid for any period beyond the end of the month in which such death occurred.

GENERAL PROVISIONS

Entire Contract: This Certificate (including any endorsements, riders or amendments), constitute the entire contract between the parties. Any statement made by You in the Application shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any Covered Person whose eligibility has been accepted by Us shall void the insurance or reduce the benefits under this Certificate or be used in defense to a claim hereunder in the absence of fraud.

Changes: To be valid, any change or waiver must be in writing. It must be signed by our President or Secretary and be attached to this Certificate. No agent has authority to change or waive any part of this Certificate.

Incontestability: (a.) After 2 years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements, made in the Application shall be used to void coverage under this Certificate or to deny a claim for loss incurred or disability (as defined in this Certificate) commencing after the expiration of such 2 year period. (b.) No claim for loss incurred or disability (as defined in this Certificate) commencing after 2 years from the date of issue of this Certificate 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 has existed prior to the effective date of coverage of this Certificate.

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

Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under this Certificate terms.

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

Time Period: For purposes of effective dates and ending dates under this Certificate, all days begin at 12:01 a.m. and end at 12:00 midnight at the Covered Person's address.

CLAIMS PROVISIONS

Assignment

This coverage may not be assigned. Benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Claimant to Us at 5 Christopher Way, Eatontown, NJ 07724 or our Administrator at *21001 N. Tatum Blvd., Suite 1630-646 Phoenix, AZ 85050* or to any authorized agent of Ours, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Claim Forms

We, upon receipt of a written notice of claim, will furnish to the Covered Person such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished within 15 days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within the time fixed in this Certificate for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us, in the case of a claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in the case of a claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Indemnities payable under this Certificate for any loss other than a loss for which this Certificate provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this Certificate provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of this Certificate shall be payable to the estate of the Covered Person, or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release, the Insurer may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled thereto. Any payment made by the Insurer in good faith pursuant to this

provision shall fully discharge the Insurer to the extent of such payment.

Subject to any written direction of the Covered Person in an application or otherwise, all or a portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical or surgical service may, at the Insurer's option, and unless the Covered Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

Change of Beneficiary

You have the right to change Your beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary. A beneficiary may be changed by filling out a new beneficiary form. You can get this form from Administrator or Us. The form must be received and recorded by Administrator or Us before the change of beneficiary becomes effective.

Physical Examination and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose Injury is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Certificate. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. If these time limits are less than allowed by the laws of the State where the Covered Person lives, these limits are extended to meet the minimum time allowed by such law.

Facility of Payment

Whenever payments that should have been made under this Certificate are made by any other policy, We shall have the right, exercisable at Our sole discretion, to pay over to any policy making such other payments any amounts We shall determine are warranted in order to satisfy the intent of this provision. The amounts so paid shall be considered benefits paid under this Certificate and, to the extent of such payments, We shall be fully discharged from liability under this Certificate.

Right of Recovery/ Subrogation

You must refund to Us any overpayment of benefits that occurs because a third party was liable to pay certain of Your expenses due to a wrongful act, negligence or omission. The refund will equal the amount We paid under this Certificate. If the refund is due from another person or organization, You must help Us obtain the refund. Our right to be reimbursed has priority over Your right to be made whole. This means that Our right of recovery applies even if Your entire loss has not been compensated. However, the amount of Our recovery will be reduced by a proper share of Your legal fees and Your expenses needed to obtain the refund.

We have the right to pursue a refund or recovery even if You do not do so. This is called subrogation. You must help Us use this right when requested. Our right of subrogation applies even if Your entire loss has not been compensated.

Claimant and Policyholder Cooperation Provision

Failure of a claimant or Policyholder to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Conformity With State Law

Any provision of this Certificate which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

When used throughout this document "Company", "Our", "We", or "Us" means

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

Internal Grievance Contact Representative

The Insured Person, the Insured Person's Representative or Health Care Provider acting on behalf of the Insured Person may contact Our designated employee or representative who has responsibility for Our internal grievance process at:

Sharon Mattingly
United States Fire Insurance Company
5 Christopher Way
Eatontown, New Jersey 07724
(732) 918-4747

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60 days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30 days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination. You also have the right to your Grievance reviewed by a managerial level person or group.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20 days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the Frist Level Review for an Adverse Determination. Within 10 business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) The name, address, and telephone number of a person designated to coordinate the Grievance Review for the Company.
(2) A statement of your rights, including the right to:
- Attend the Second Level Review.
- Present his/her case to the review panel.
- Submit supporting materials before and at the review meeting.
- Ask questions of any member of the review panel.
- Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- Request and receive from us free of change, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45 days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15 days prior to the date. The review meeting will be held during regular business hours at a location reasonably accessible to you. In cases where a face-to-face meeting is not practical for geographical reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) Were not previously involved in any matter giving rise to the Second Level Review;
(2) Are not employees of the Company or Utilization Review Organization; and
(3) Do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 45 calendar days after completing the review meeting unless we request an extension to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed 45 days from the end of the initial period unless the initial period is extended due to your failure to submit information necessary to decide the claim on appear. If the extension is due to your failure to submit information, the period for making the determination shall be tolled until the date the insured responds to the request for additional information. The decision must include:

(1) The name(s), title(s) and qualifying credentials of the members of the review panel.
(2) A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts.
(3) The review panel's recommendation to the Company and the rationale behind the recommendation.
(4) A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation.
(5) In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination.
(6) The rationale for the Company's decision if it differs from the review panel's recommendation.
(7) A statement that the decision is the Company's final determination in the matter.
(8) In the event we uphold the results of the prior review, you have the right to present your grievance to the Commissioner for review.

EXPEDITED REVIEW

Your are eligible for an expedited review when the time frames for an Informal, formal First Level Review or Second Level Review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24 hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72 hours after the review has commenced. Written communication of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level Reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

RETENTION OF GRIEVANCES

Copies of all grievances and responses will be available at our principal office for inspection by the Commissioner for 2 years following the year the grievance was filed.

SUMMARY OF COVERAGE AND LIMITATIONS AND EXCLUSIONS UNDER THE MICHIGAN LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION

Introduction

Michigan residents who purchase life insurance, annuities or health insurance should know that most insurance companies licensed in Michigan to write these types of insurance are members of the Michigan Life & Health Insurance Guaranty Association (MLHIGA). The purpose of this association is to assure that policyholders may be protected, **within limits**, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, MLHIGA will assess its other member insurance companies for the money to pay the covered claims of insured persons who live in Michigan and, in some cases, to keep coverage in force. If coverage is provided, it may be subject to limitations or exclusions and may require residency in Michigan. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Guaranty Association Act

The Michigan Life & Health Insurance Guaranty Association Act, Chapter 77 of the Insurance Code of 1956, MCL 500.7701 to 500.7780, details the specific coverage, exemptions and limitations provided to certain policyholders. The general information provided by this summary or the MLHIGA web site does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of MLHIGA. For a definitive statement of the law governing MLHIGA, you must refer to the MLHIGA Act itself. If there is any inconsistency between this summary or the MLHIGA web site and any applicable law, then such law will control.

Coverage

Generally, individuals will be protected by MLHIGA if they reside in Michigan and own a life, health or annuity contract issued by a member insurer licensed in Michigan or if they reside in Michigan and are insured under a group life or health insurance contract issued by a member insurer licensed in Michigan. For owners of unallocated annuity contracts, coverage will be provided if the contract is issued in connection with a specific plan whose sponsor has its principal place of business in Michigan or if the individual is a resident of Michigan and the contract is issued in connection with a government lottery. For payees (or beneficiaries of deceased payees) of structured settlement annuities, coverage will be provided only if the payee is a resident of Michigan. In limited situations, coverage might also be available to certain nonresidents.
You may find out if your insurance company is licensed in Michigan by contacting the Department of Insurance and Financial Services at P.O. Box 30220, Lansing, Michigan 48909-7720, telephone number (517) 284-8800 or 877-999-6442. Please be aware, although licensed in Michigan, policies issued by the following entities are not covered by MLHIGA: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities.

Protection can be provided in one of several different ways. For example, MLHIGA may provide coverage directly or a financially sound insurer may take over the troubled company's assets and policies and assume responsibilities for continuing coverage and paying covered claims. MLHIGA may also work with other state guaranty associations to develop an overall plan to provide protection for the failed insurer's policyholders. In any case, delays could be necessary to sort out the affairs of the financially troubled insurer.

Limits on Amount of Coverage

The MLHIGA Act limits the amount MLHIGA is obligated to cover for each insolvent company as follows:

(1) MLHIGA cannot cover more than what the insurance company would owe under a policy or contract;

(2) for any one life, regardless of the number of policies or contracts held with the same company, MLHIGA will cover a maximum of:

(a) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(b) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; (c) for health insurance:

(i)$300,000 in disability income insurance benefits or long-term care benefits;

(ii) $500,000 in basic hospital, medical, and surgical insurance benefits; (iii) $100,000 in all other health insurance benefits.

(d) In no event is the association obligated to cover more than an aggregate of $300,000 in all benefits (other than basic hospital, medical, and surgical benefits) for any one life.

The limits mentioned above are applied per any "one life" per insolvent company.

As an example of this "one life" limitation, if you own three annuities with the same annuitant from the same insurance company, each worth $100,000 and that company is declared insolvent and ordered liquidated, only $250,000, **in total**, may be protected because that is the maximum amount protected under the MLHIGA Act for all annuities from a single insurer.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund **governmental retirement plans only** under sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits per participating individual; for covered unallocated annuities that fund other plans, benefits are not available on an individual basis and a special limit of $5,000,000 applies to the contract holder, regardless of the number of contracts held with the same company or number of persons covered by the plan. Coverage is dependent on plan sponsor having its principal place of business in Michigan. In all cases, of course, the contract limits also apply.

Exclusions from Coverage

Persons holding policies otherwise covered are **not** protected by MLHIGA if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not authorized to do business in Michigan.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate set by formula in the MLHIGA Act;
- dividends;
- obligations not arising from the express written terms of the policy or contract;
- insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets owned by benefit plan;
- interest determined by external reference that has not been credited to the policy or is subject to forfeiture;
- employers' plans that are self-funded (that is, not fully insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts, unless they fund a government lottery or a benefit plan of an employer, association or union, however, unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered. An unallocated annuity contract is an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. The term shall also include, but not be limited to, guaranteed investment contracts and deposit administration contracts;
- policies issued by the following entities, even though licensed in Michigan: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities;
- a portion of a policy or contract to the extent that the assessments required by section 7709 of the MLHIGA Act for the policy or contract are preempted by federal or state law;
- a policy or contract providing any hospital, medical, prescription drug , or other health care benefits under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152, or under regulations issued under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152.
- MLHIGA **will not** provide duplicate coverage to **any** individual that is also covered by the laws of another state or another state's guaranty association.

Contact

The intent of this summary and the MLHIGA web site is to briefly explain how MLHIGA provides protection to Michigan policyholders in the event their insurance company becomes insolvent. If you have any questions that are not answered here, you should contact MLHIGA or consult with your attorney.

Disclaimer

The information provided by this summary and the MLHIGA web site is subject to change without notice. The statements made herein are for information purposes only. MLHIGA has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the insurer is declared insolvent. For these reasons, no final determination of coverage can be made until an insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind MLHIGA in any way. Finally, this summary and the MLHIGA web site are for general information purposes and should not be relied upon as legal advice.

January 14, 2016

MICHIGAN NOTICE

This product is not considered “qualified health coverage” for purposes of no-fault insurance under MCL 500.3107d(7)(b)(i).

CRUM & FORSTER
A FAIRFAX COMPANY

PRIVACY NOTICE

Monitor Life Insurance Company of New York, United States Fire Insurance Company, The North River Insurance Company and affiliates within Crum & Forster (collectively, "The Company") values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information including nonpublic personal information about our customers and claimants. Nonpublic personal information means information that allows someone to identify or contact you ("Information"). We are committed to protecting such Information and we will comply with all applicable federal and state laws and regulations. This notice describes how we collect, use and share your Information, your rights with respect to insurance products issued by The Company and our legal duties and privacy practices. State laws require that we provide this notice. Please review this Notice and keep a copy of it with your records.

Your privacy is our concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. The Company limits the collection, use, and disclosure of such information to only what is needed to properly produce, underwrite and service its insurance products and/or fulfill legal or regulatory requirements. The Company maintains administrative, technical and physical safeguards that comply with state and federal regulations to protect your Information. We also limit employee access to Information to those with a business reason for knowing such Information and we take measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our Information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical providers, insurance support organizations, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

The Company collects nonpublic information to conduct its business of producing, underwriting, servicing and administering its insurance products. If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

Access to non-public personal information is limited to those employees, and authorized representatives, attorneys and service providers who specifically need such information to conduct their business responsibilities. In addition, we may disclose all the information that we collect about you to affiliated companies and nonaffiliated third parties (as permitted by law), such as:

- Insurance companies;
- Insurance agencies;
- Loss adjusters;
- Medical providers;
- Third party non-insurance service providers;
- Third party administrators;
- Medical bill review companies;
- Reinsurance companies; and
- Similar service providers.

Crum & Forster requires its service providers to abide by privacy laws in handling non-public personal information obtained through its business relationship with Crum & Forster. Additionally, Crum & Forster may disclose non-public personal information to third parties as allowed or required by law. For example, Crum & Forster may release your Information to comply with reporting requirements, to comply with a subpoena, warrant, legal process or other order or inquiry of a court, governmental agency or state or federal regulator, or to fulfill C&F's obligations to its insurers and reinsurers We may also share your personal information in order to establish or exercise our rights, to defend against a legal claim, to investigate, prevent, or take action regarding possible illegal activities, suspected fraud, safety of person or property, or a violation of our policies.

If you conclude your relationship with the Company, the Company will continue to safeguard your privacy in accordance with the standards described in this notice. The Company maintains physical, electronic and procedural safeguards to protect non-public personal information.

About Our Websites

We may collect information via technology about how you use our website, including the elements you have interacted with, metadata, and other details about these elements, clicks, change states, and other user actions. This information is used primarily to provide, maintain, protect, and improve our current products and to develop new ones.

We may use cookies on certain pages of our site. Cookies are stored on your computer, not on our site. Most cookies are "session cookies" which means that they are automatically deleted at the end of each session. A cookie itself does not have the ability to automatically collect personal information about you. A cookie can store certain information that identifies your computer to us so that you do not need to re-enter that information as frequently when you use our site. The cookie does not contain your password.

We reserve the right to change our policy regarding cookies and the collection of information from visitors at any time without advance notice. Should any new policy be put into effect, we will post it on this website, and the new policy will apply only to information collected thereafter. You may opt out of receiving cookies or delete any prior cookies by changing your specific internet browser settings. The privacy of communication over the internet cannot be guaranteed. If you are concerned about the security of your communication, we encourage you to send your correspondence through the postal service or use the telephone to speak directly to us. We do not represent or warrant that the site, in whole or in part, is appropriate or available for use in any particular jurisdiction. Those who choose to access the site, do so on their own initiative and at their own risk, and are responsible for complying with all local laws, rules and regulations. We do not assume any responsibility for any loss or damage you may experience or incur by the sending of personal information over the internet by or to us. This Usage Agreement shall be governed by the laws of the United States and of the State of New Jersey, without giving effect to its conflict of laws provisions.

Please know that The Company has not and will not sell any consumers' personal information. We do not sell your nonpublic personal information to any third parties nor do we use it for marketing purposes.

How to contact us

If you have any questions about this Privacy Notice or about how we use the information we collect, please contact us at:

Crum & Forster Legal Department
305 Madison Avenue
Morristown, NJ 07960
privacyinformation@cfins.com

Changes to this Privacy Notice

We may revise this notice at any time. If we make material changes, we will notify you as required by law.

For California Residents Only:

If you are a California resident, you may be entitled to additional rights over your Information. We do not, and will not, sell Information collected from you. The California Consumer Privacy Act (CCPA) provides California residents, upon a verifiable consumer request, certain rights that include:

- ***The right*** to request that we disclose (1) The categories of personal information that we have collected about you; and (2) The categories of personal information that we have disclosed about you for a business purpose
- ***The right*** to request that we delete the personal information it has collected from you, subject to certain legal exceptions, for example, when such personal information is necessary to fulfill or comply with our legal obligations.

The right to be protected from discrimination for exercising your CCPA rights. If you choose to exercise your privacy rights, we will not charge you different prices or provide different quality of services unless those differences are related to your information.

You may designate an authorized agent to act on your behalf and make a request of us under the CCPA.

To exercise your rights under the CCPA or to seek assistance, please do one of the following:

- If you would like to make a Request to Know, go to http://www.cfins.com/request-to-know-california-residents/ or call 1.844.254.5754
- If you would like to make a Request to Delete, http://www.cfins.com/request-to-delete-california-residents/ or call 1.844.254.5754
- Fill out and send back to us the Request to Know / Request to Delete form to:

  Crum & Forster Legal Department
  PO Box 1973
  305 Madison Avenue
  Morristown, NJ 07962
  privacyinformation@cfins.com

We will attempt, where practical, to respond to your requests and to provide you with additional privacy-related information. We will confirm receipt of verifiable consumer requests within ten (10) days of receipt. You may only make a verifiable consumer request for personal information twice within a twelve (12) month period. We cannot respond to your request if we cannot verify your identity or authority to make the request and confirm the personal information relates to you. Any consumer with a disability may access this notice by contacting us at the address, email or toll free number listed above.

We may change this California Privacy Notice and our privacy practices over time. Our most current Privacy Policy and California Privacy Notice can be found on our website at http://www.cfins.com/terms/.

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

KOBA KVIRIKASHVILI

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Lawrence Kalikhman Kalikhman & Rayz, LLC 1051 County Line Road Suite A Huntingdon Valley, PA 19006

DEFENDANTS

UNITED STATES FIRE INSURANCE COMPANY, et al.

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☒ 4
Citizen of Another State	☐ 2	☒ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☒ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:

Brief description of cause:
Unlawful attempt to subrogate from proceeds of an insurance claim

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
09/23/2025

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

10/2024

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DESIGNATION FORM

Place of Accident, Incident, or Transaction: Nationwide

RELATED CASE IF ANY: Case Number:_____ Judge:_____

1. Does this case involve property included in an earlier numbered suit? Yes ☐
2. Does this case involve a transaction or occurrence which was the subject of an earlier numbered suit? Yes ☐
3. Does this case involve the validity or infringement of a patent which was the subject of an earlier numbered suit? Yes ☐
4. Is this case a second or successive habeas corpus petition, social security appeal, or pro se case filed by the same individual? Yes ☐
5. Is this case related to an earlier numbered suit even though none of the above categories apply? If yes, attach an explanation. Yes ☐

I certify that, to the best of my knowledge and belief, the within case ☐ **is** / ☒ **is not** related to any pending or previously terminated action in this court.

Civil Litigation Categories

A. Federal Question Cases:

- ☐ 1. Indemnity Contract, Marine Contract, and All Other Contracts)
- ☐ 2. FELA
- ☐ 3. Jones Act-Personal Injury
- ☐ 4. Antitrust
- ☐ 5. Wage and Hour Class Action/Collective Action
- ☐ 6. Patent
- ☐ 7. Copyright/Trademark
- ☐ 8. Employment
- ☐ 9. Labor-Management Relations
- ☐ 10. Civil Rights
- ☐ 11. Habeas Corpus
- ☐ 12. Securities Cases
- ☐ 13. Social Security Review Cases
- ☐ 14. Qui Tam Cases
- ☐ 15. Cases Seeking Systemic Relief ***see certification below***
- ☐ 16. All Other Federal Question Cases. *(Please specify)*:_____

B. Diversity Jurisdiction Cases:

- ☒ 1. Insurance Contract and Other Contracts
- ☐ 2. Airplane Personal Injury
- ☐ 3. Assault, Defamation
- ☐ 4. Marine Personal Injury
- ☐ 5. Motor Vehicle Personal Injury
- ☐ 6. Other Personal Injury (*Please specify*):_____
- ☐ 7. Products Liability
- ☐ 8. All Other Diversity Cases: *(Please specify)*_____

I certify that, to the best of my knowledge and belief, that the remedy sought in this case ☒ **does** / ☐ **does not** have implications beyond the parties before the court and ☒ **does** / ☐ **does not** seek to bar or mandate statewide or nationwide enforcement of a state or federal law including a rule, regulation, policy, or order of the executive branch or a state or federal agency, whether by declaratory judgment and/or any form of injunctive relief.

ARBITRATION CERTIFICATION (CHECK ONLY ONE BOX BELOW)

I certify that, to the best of my knowledge and belief:

☒ Pursuant to Local Civil Rule 53.2(3), this case is not eligible for arbitration either because (1) it seeks relief other than money damages; (2) the money damages sought are in excess of $150,000 exclusive of interest and costs; (3) it is a social security case, includes a prisoner as a party, or alleges a violation of a right secured by the U.S. Constitution, or (4) jurisdiction is based in whole or in part on 28 U.S.C. § 1343.

☐ None of the restrictions in Local Civil Rule 53.2 apply and this case is eligible for arbitration.

NOTE: A trial de novo will be by jury only if there has been compliance with F.R.C.P. 38.