

**SCHEDULE OF COVERAGES**

Policyholder: VFIS TRUST

Policy Number:

Participating Organization:

VFP 2243-7463C-01

West Roane County Volunteer Fire Department  
 PO Box 417  
 Rockwood, TN 37854

Policy Effective Date: 01/03/2006

Term: 3 Year

Policy Expiration Date: 01/03/2009

Premium: \$ 3,538

This summary of coverage provides only those following benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by entry of the word "none" are not provided.

PART	COVERAGE	AMOUNT OF INSURANCE
<b>I.</b>	<b>Loss of Life Benefits</b>	
A.	Accidental Death Benefits	
	(i) Accidental Death Indemnity Benefit .....	\$ 25,000
	(ii) Seat Belt Benefit Amount .....	\$ 5,000
B.	Illness Loss of Life Benefit .....	\$ 25,000
C.	Dependent Benefit Amount (Per Dependent Child) .....	\$ 10,000
D.	Spousal Support Benefit Amount .....	\$ 5,000
E.	Memorial Benefit Amount .....	\$ 2,000
<b>II.</b>	<b>Lump Sum Living Benefits</b>	
A.	Accidental Dismemberment Principal Sum .....	\$ 25,000
B.	Vision Impairment Benefit .....	\$ 25,000
C.	Optional Permanent Physical Impairment Principal Sum - Injury Only .....	\$ 25,000
D.	Cosmetic Disfigurement Resulting From Burns Principal Sum .....	\$ 25,000
E.	HIV Positive Benefit .....	\$ 25,000
<b>III.</b>	<b>Weekly Income Benefits</b>	
A.	Total Disability Benefit	
	(1) Total Disability Weekly Income Benefit (first 28 days) .....	\$ 150
	(2) Total Disability Maximum Weekly Amount (after 28 days) .....	\$ 300
	(3) Total Disability Minimum Weekly Amount .....	\$ 38
B.	Partial Disability Benefit	
	(1) Partial Disability Weekly Income Benefit (first 28 days) .....	\$ 75
	(2) Partial Disability Maximum Weekly Amount (after 28 days) .....	\$ 150
	(3) Partial Disability Minimum Weekly Amount .....	\$ 19
<b>IV.</b>	<b>Occupational Retraining Benefit Maximum Amount</b> .....	\$ 20,000
<b>V.</b>	<b>Weekly Permanent Physical Impairment Benefit</b>	
<b>VI.</b>	<b>Optional Weekly Permanent Physical Impairment COLA Benefit</b> .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>VII.</b>	<b>Medical Expense Benefits</b>	
A.	Medical Expense Maximum Amount .....	\$ 2,500
	Medical Expense Benefit Options	
	1. Excess of Workers' Compensation or No-Fault Auto Insurance Benefits .....	<input checked="" type="checkbox"/>
	2. Excess of Workers' Compensation, No-Fault Auto Insurance and Other Group Insurance .....	<input type="checkbox"/>
	3. Primary Medical Expense Benefit .....	<input type="checkbox"/>
B.	Cosmetic/Plastic Surgery Maximum Amount .....	\$ 10,000
<del>C.</del>	<del>Post Traumatic Stress Disorder Maximum Amount .....</del>	<del>\$ 10,000</del>
<del>D.</del>	<del>Critical Incident Stress Management Maximum Amount (Per Covered Activity) .....</del>	<del>\$ 2,500</del>
E.	Family Expense Benefit .....	\$ 100
<b>VIII.</b>	<b>Optional Benefits</b>	
A.	Weekly Hospital Indemnity Benefit .....	\$ none
B.	Additional Disability Weekly Benefit .....	\$ none
C.	24 Hour Accidental Death and Dismemberment Benefit .....	\$ none
D.	Non-Covered Activity Accidental Death and Dismemberment Benefit .....	\$ none

001N2200