CHRISTIAN·BAKER
COMPANY
INSURANCE & BONDING

I hereby apply for General Liability coverage and enroll for Accident Insurance as offered through the National Wildlife Control Operators Association (NWCOA) described in the Certificate of Coverage. I understand that coverage will not take effect until the full premium and application/enrollment have been received by our authorized representative.

Name of Owner/Applicant_____ **Our Company is** ____Individual
____Partnership
Business Name _____ ____LLC
____Corporation

Street Address_____

City_____State_____Zip_____

Telephone Number: ____-____-_____ **Fax Number**: ____-____-_____ **Number of Employees** _____

EIN _____-_____-_____ **E-mail address**: _____

Name of owner: _____

Beneficiary Name_____ Relationship to owner_____

Name of co-owner: _____

Beneficiary Name_____ Relationship to co-owner_____

Name of Technician_____

Beneficiary Name_____ Relationship to technician_____

Name of Technician_____

Beneficiary Name_____ Relationship to technician_____

Attach additional sheet for additional technicians.

Do you currently have other Accident or Medical insurance in force? _____

If yes, Name of Company and Policy Number_____

Requested Effective Date of Coverage_____

Have you had any claims? _____ If yes, describe and list amount paid by your insurance company on a separate sheet.

General Liability Limit requested:

PLEASE CIRCLE ONE

($300,000 / $600,000) ($500,000/ $1,000,000) ($1,000,000/$2,000,000)

Pesticide endorsement Yes___ No ___ If yes, Basic _____ Broader _____

If Pest Endorsement, Transit Pollution: Yes____ No ____ If yes, $25,000.00 ____ $50,000 ____

Are you a Member of the NWCOA? Yes _____ No____

Are you a Certified Wildlife Control Professional with NWCOA? Yes _____ No_____

Accident Insurance Coverage Limits

are as stated in the attached Accident Insurance Description of Coverage.

NWCOA Program Page Two

By signing below, I acknowledge that I have read and understand the following statements.

Name of Applicant/Enrollee_____

I understand that I must be a member in good standing with NWCOA to qualify for the insurance coverage offered on this enrollment form.

Applicant/Enrollee signature _____ Date _____

I understand that under the accident policy any claim that occurs while I am operating a vehicle or riding as a passenger in a vehicle, the claim will be considered a "not at work claim" and would be paid under the "24 hour coverage". You are not at work if you are in a vehicle.

Applicant/Enrollee signature _____ Date _____

I understand that under the accident policy, any claim for "hernia" will not be considered an accident. There is no coverage for hernia under the accident policy.

Applicant/Enrollee signature _____ Date _____

I acknowledge that there is no coverage under the general liability policy or under the accident policy for any work involving bears or alligators.

Applicant/Enrollee signature _____ Date _____

I acknowledge that there is no coverage under the general liability policy or under the accident policy (at work coverage) for anything other than Nuisance Wildlife Control Operations and Exclusion Work. This policy provides no Liability coverage for anything that is not Nuisance Wildlife Control Operations and Exclusion Work.

Applicant/Enrollee signature _____ Date _____

I understand that my policy premium is "fully earned" when the policy is issued. I understand that "fully earned" means that I would not get a refund on my policy if I cancel the policy prior to its expiration.

Applicant/Enrollee signature _____ Date _____

I acknowledge that I have received and understand the Accident Insurance Description of Coverage and hereby request coverage from Berkley Life and Health Insurance Company or StarNet Insurance Company for an Accident Insurance Policy. I understand that insurance will be in force as of the effective date indicated in the issued policy if this request is accepted and the required premium is received by the insurer.

I declare that all information provided above and in any attachments hereto is true and correct and understand that such information is material to insurer's decision to provide this insurance, and that any insurance will be provided at the insurer's sole discretion, in reliance upon the truth of such information.
I understand that coverage under the policy is ACCIDENT ONLY coverage. It does not constitute comprehensive health insurance or major medical insurance coverage. **It therefore does not, nor is it intended to, satisfy the "minimum essential coverage" requirements of the Patient Protection and Affordable Care Act.**

I understand that coverage does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit the insurer from offering or providing insurance.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (Fraud language varies by state. Please see Fraud Warnings page.)

Applicant/Enrollee signature _____ Date _____

Please make check payable to Christian-Baker Co.

Christian-Baker Co.
P.O. Box 158
Camp Hill Pa 17001
Phone: 717-761-4712
Fax: 717-761-5810
E-mail: JimP@buybestins.com

Fraud Warnings

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

A false statement in an application shall not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR RESIDENTS OF KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

FOR RESIDENTS OF KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FOR RESIDENTS OF MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FOR RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FOR RESIDENTS OF OHIO AND OKLAHOMA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FOR RESIDENTS OF OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ACCIDENT INSURANCE DESCRIPTION OF COVERAGE

Underwritten by Berkley Life and Health Insurance Company and/or StarNet Insurance Company

ELIGIBILITY:

Class 1:

- All active listed technicians of the Policyholder including the owner operator and temporary workers excluding occupational duties.

Class 2:

- All active listed technicians of the Policyholder including the owner operator and temporary workers during occupational duties.

Class 3:

- All active listed technicians of the Policyholder including the owner operator and temporary workers excluding occupational duties while driving.

COVERED ACTIVITIES:

Class 1:

- 24–hour coverage excluding occupational activities.

Class 2:

- Occupational Activities –we will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is in the course of their job on or off the Policyholder's premises. This coverage does not include commuting between home and place of work.

Class 3:

- 24–hour coverage while driving.

PREMIUM: Annual premium will be determined by the number of employees.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Applies to All Classes

Principal Sum:	$10,000
Time Period for Loss:	365 days

Aggregate Limit of Liability $100,000

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Applies to Class 1 and Class 3

Total Benefit Maximum for all Accident Medical	$500
Loss Period (first Covered Expenses must be incurred within):	30 days after the date of the Covered Accident
Benefit Period:	104 weeks from the date of the Covered Accident
Deductible:	$25
Coinsurance Factor for all Covered Expenses:	100%
Terms of Payment	Primary Excess over an Initial Amount of $100

Applies to Class 2

Total Benefit Maximum for all Accident Medical	$5,000
Loss Period (first Covered Expenses must be incurred within):	30 days after the date of the Covered Accident
Benefit Period:	104 weeks from the date of the Covered Accident
Deductible:	$25
Coinsurance Factor for all Covered Expenses:	100%
Terms of Payment	Primary Excess over an Initial Amount of $100

Accident Medical Expense benefits may be available on an allocated or unallocated basis as shown, that is to say there may be specific limits or coinsurance rates on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and coinsurance factor (unallocated).

Applies to All Classes

Physiotherapy	$50 per visit up to a maximum of 5 visits per Covered Accident

Any Deductibles, Coinsurance Factors, Benefit Periods and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.

Capitalized terms in this Description of Coverage will have the meaning as defined within the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within 365 days of the date of the accident that caused the Injury, the Company will pay the percentage of the Principal Sum shown below for that loss. If multiple losses occur, only one Benefit, the largest, will be paid for all Covered Losses due to the same Covered Accident.

Loss of:	**Benefit:** (Percentage of Principal Sum)
Life	100%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Uniplegia	25%
Thumb and Index Finger of the Same Hand	25%
Four fingers of the Same Hand	25%

"Member" means Hand or Foot, Arm or Leg, Sight, Speech and Hearing. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of Arm or Leg" means complete severance through or above the elbow or knee joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body. "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Quadriplegia" means total Paralysis of both upper and lower limbs. "Uniplegia" means total Paralysis of one lower limb or one upper limb.

Aggregate Limit of Liability

The maximum amount the Company will pay on behalf of all Covered Persons for all covered Accidental Death and Dismemberment losses resulting from the same Accident will not exceed the Aggregate Limit of Liability as described in this Description of Coverage.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

If a Covered Person suffers an Injury that requires him or her to be treated by a Physician within the Loss Period, the Company will pay up to the Accident Medical and Dental Expense Benefits maximum amount for Covered Medical Expenses incurred by the Covered Person that result directly, and from no other cause, from all Injuries caused by the covered accident. These benefits are subject to the Deductibles, Coinsurance Factors, and Benefit Periods outlined in the schedule section above.

Accident Medical Expense Benefits are only payable:

1) for Usual and Customary Charges incurred after the Deductible, if any, has been met;
2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
3) for Covered Medical Expenses incurred within the designated Benefit Period after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses include:

1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
4) Registered Nurse Services Expenses for private duty nursing while a Covered Person is Hospital Confined, when services are ordered by a Physician.
5) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
6) Outpatient surgery expenses, including Ambulatory Surgical Center.
7) Outpatient surgical room and supply expenses for use of the surgical facility.
8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
9) Physician non-surgical treatment/examination expenses (excluding medicines) including the Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.
10) Second surgical opinion expenses.
11) Physician surgical expenses. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
12) Assistant Surgeon expenses when Medically Necessary.
13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
14) Outpatient laboratory test expenses.
15) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
16) Post-surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
17) X-ray expenses (including reading charges) not including dental x-rays.
18) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.

19) Outpatient registered nurse services if ordered by a Physician.
20) Ambulance expenses for transportation from the Accident site to the Hospital.
21) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
22) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
23) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
24) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
25) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

TERMS OF PAYMENT FOR ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Primary Excess: Covered Medical Expenses incurred by a Covered Person, subject to any cost containment limits set out in the schedule section above, will be paid on a primary basis up to the first $100 of incurred covered expenses. Covered Medical Expenses incurred over and above the initial $100 will be paid on an excess basis after any other valid and collectible insurance payments.

Failure by a Covered Person to follow the terms and conditions and/or failure to utilize the network providers and facilities of his or her primary coverage will result in a benefit reduction of Covered Medical Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an accident when the accident occurs outside the geographic area served by the Covered Person's primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

EXCLUSIONS

The Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an accidental bodily Injury, unless otherwise covered under the policy by Additional Benefits:

1. Suicide, self–destruction, attempted self–destruction or intentional self–inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Disease or disorder of the body or mind.
6. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
7. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.

8. Intoxication or being under the influence of any drug or narcotic.
9. Violation or in violation or attempt to violate any duly–enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
10. Conditions that are not caused by a Covered Accident.
11. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
12. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
13. Travel or activity outside the United States.
14. Participation in any motorized race or speed contest.
15. Aggravation or re–injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
16. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
17. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
18. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
19. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person.
20. Treatment of a hernia whether or not caused by a Covered Accident.
21. Treatment of Osgood–Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
22. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
23. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
24. Mental or nervous disorders, except as specifically provided in this policy.
25. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
26. Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.
27. Loss resulting from participation in any activity not specifically covered by this Policy.
28. Any treatment, service or supply not specifically covered by this Policy.
29. Eyeglasses, contact lenses, hearing aids.
30. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in the Policy.
31. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    ii. While being used for any test or experimental purpose; or
    iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or

iv. while traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.

Except as a fare paying passenger on a regularly scheduled commercial airline.

IMPORTANT INFORMATION:

This Description of Coverage presents a brief description of coverage provided under insurance policy form series AH51051, underwritten by Berkley Life and Health Insurance Company (domiciled in Iowa - California Certificate of Authority #08527) and/or StarNet Insurance Company (domiciled in Iowas - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690, and is based on the information submitted and rates in effect on the date you enroll for coverage. Please refer to the actual policy for a complete description of all the coverages and benefits along with all the conditions, limitations and exclusions applicable under the policy. Coverage terms, conditions, limitations and exclusions may vary or may not be available in all states. If there is a conflict between this Description of Coverage and the issued policy, the issued policy will prevail.

The insurance described in this Description of Coverage provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

The coverage described in this Description of Coverage does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from offering or providing insurance.