Dear Policyholder:

It is a pleasure to welcome you as a new policyholder of the Life Insurance Company of North America (LINA), a CIGNA Company. We are pleased to provide the coverage for your New Jersey Temporary Disability Benefit (TDB) program.

The Following Forms are enclosed for your records:

- The master policy and any modifying Endorsements (Endorsement #1)
- A copy of the signed New Jersey DP-1 Form for your records
- A Notice of Your Employer's New Jersey Temporary Disability Benefit Plan and any modifying Endorsements (Endorsement #2). These documents are to be posted conspicuously at the site of your place of business.

If you have any questions or if you need assistance, please contact your Account Manager or Account Service Representative.

Very truly yours,

Matthew G. Manders, President

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA.

A Stock Insurance Company, herein called the Company

IN CONSIDERATION of the payment of the premium and in reliance upon the statements contained in the application, a copy of which forms a part hereof, the Company agrees with the employer named in the application, subject to the terms of this policy, as follows:

PART I. Benefits. The Company will afford the coverage and pay the disability benefits to which any employee would be entitled because of employment within any insured class as stated in item 2 of the application while this policy applies to such class, if he were covered under the State Plan, as defined in Article III and limited in Section 6 of the Temporary Disability Benefits Law of the State of New Jersey, hereinafter called "said law". Said law shall include any laws amendatory thereof or supplementary thereto which are or may become effective during the policy term.

This policy provides benefits in accordance with a private plan established by the employer pursuant to said law. If because of a period of disability an employee becomes entitled to benefits hereunder, the employee shall not be paid less per week, nor for fewer weeks, than he would be entitled to be paid under said law for said disability were the employee not covered under any private plan; provided, the maximum amount payable hereunder in any twelve month period shall not be more than the employee would have been entitled to receive had such employee been covered by the State Plan during said twelve month period and, if an employee is in concurrent employment with two or more employers having private plans, the Company will pay to the employee its pro rate share of benefits in accordance with regulations applicable to concurrent coverage. The maximum total benefits payable to the employee in any 12 month period under said law shall be applicable separately to each period of disability.

PART ll. PAYMENT OF ASSESSMENTS. The Company agrees to pay all assessments which may be levied against the employer in accordance with the provisions of said law, but only to the extent that such assessments are based upon wages paid by the employer to employees insured under this policy while this policy is in full force.

PART lll. EMPLOYEE CONTRIBUTIONS. No greater contribution shall be required of any employee toward the premium for this insurance than the amount he would have to contribute to the New Jersey State Disability Benefits Fund were he insured thereunder.

PART lV. PREMIUM. The premium for this policy shall be computed on the basis stated in item 5 of the application. On the first day of each calendar quarter after the effective date of this policy, premium shall become due for the insurance provided during the previous calendar quarter. The amount of premium due on each such premium due date shall be determined by applying the premium rate then in effect to the total wages subject to unemployment insurance taxes for the previous calendar quarter (excluding wages over $33,500.00 per calendar year) as reported to the Division of Employment Security of the Department of Labor and Industry of New Jersey, hereinafter called "the Division." If this policy was not in effect for the full calendar quarter, the premium computed in accordance with the foregoing shall be prorated for the period this policy was in effect. The employer shall determine the amount of each premium due and shall remit such amount in full to the Company or to its authorized agent, together with a complete copy of each quarterly report made to the Division. A period of grace of thirty days following the premium due date shall be allowed the employer for the payment of any premium. The Company reserves the right to establish new premium rates at the end of any policy year or whenever the terms of this policy are changed or whenever the Company's obligations under this policy are increased by reason of any amendment to said law or authorized regulations thereunder.

PART V. POLICY TERM. This policy is effective on the effective date stated in item 4 of the application and shall continue until terminated in accordance with the terms hereof. This policy applies only to disability commencing while this policy is in force, except as provided in section 8 (e) of said law.

PART VI. TERMINATION. This policy shall automatically terminate when the employer terminates the private plan covered hereunder or when the Division withdraws approval of said plan.

If during any 12 months period ending not less than 3 months or more than 12 months prior to any renewal date the sum of all benefits paid or payable under Part 1 of this policy exceeds 60% of the premium earned by the Company during such period or if the Company's obligations under this policy are increased by reason of any amendment to said law or authorized regulations thereunder, the Company may terminate this Policy as of the next renewal date by giving 60 days written notice to the employer at the address stated in this policy and to the Division.

If any premium remains unpaid at the expiration of the grace period, the Company may terminate this Policy by written notice to the employer at the address stated in this policy and to the Division. Such termination shall be effective on the fifteenth day after such notice is received by the Division or on the date of termination stated in such notice, whichever is the later. The employer shall be liable to the Company for the premium for the period this policy is in force after the due date of any such defaulted premium.

The insurance of an employee insured hereunder shall terminate automatically immediately upon the earliest of the following dates: (a) the date this Policy terminates provided the employee is in employment with the Employer on the date of termination of the policy; if an employee has terminated his employment with the Employer prior to the termination of this policy his insurance under this Policy shall terminate at the expiration of a period of two weeks immediately following the date of termination of his employment with the employer; (d) the date following termination of his employment with the Employer on which he becomes employed by another covered employer.

PROVISIONS

1. No statement made by the applicant for insurance shall avoid the insurance or reduce benefits hereunder, unless contained in the written application signed by the applicant. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an officer of the Company and such approval be endorsed hereon.

2. This policy, the Application of the employer, copy of which forms a part hereof, and the individual applications, if any, of the employees constitute the entire contract between the parties. No provision of the charter constitution or by-laws of the Company shall avoid this policy or be used in defense of any claim hereunder unless such provision is incorporated in full in this policy.

3. All Statements of the employer and employees contained in any such application for insurance shall be deemed representations and not warranties.

4. All new employees, in the groups or classes insured under this policy, shall be added to such groups or classes.

5. The Company shall furnish the insured employees with reasonable notice of the benefits provided by this policy either by direct notification or by conspicuous posting at the place of their employment.

6. Written notice of injuries, sickness or disease shall be given to the Company within thirty days after the commencement of disability from such injuries, sickness or disease.

Such notice given by or in behalf of the employee to the Company at Philadelphia, Pennsylvania, or to any authorized agent of the Company, with particulars sufficient to identify the employee shall be deemed sufficient notice to the Company. Failure to give such notice within such time shall not invalidate nor reduce any claim if it be-shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

7. The Company upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen days after the receipt of such notice, the person making such claim shall be deemed to have compiled with the requirement of this policy as to proof of loss upon submitting within the time fixed in this policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim it made.

8. Written proof of such loss shall be furnished to the Company at its said office, within ninety days after the termination of the period of disability for which the Company is liable. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof as such proof was furnished as soon as was reasonably possible.

9. The Company shall have the right and opportunity to examine the person of the insured employee when and so often, but not more than once a week, as it may reasonably require during the pendency of claim under this policy.

10. Subject to due proof of loss, all accrued benefits payable under this policy will be paid weekly, bi-weekly or as often as the employee is customarily paid his wages or salary during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

11. All indemnities under this policy are payable to the employee, provided, if at his death any indemnities are due as unpaid, such indemnities are payable to the surviving spouse or, it there be no surviving spouse, to the estate of the employee.

12. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, and no such action shall be brought at all unless brought within two years after the expiration of the time within which proof of loss is required by this policy. This provision does not affect in any way an employee's right of appeal under the New Jersey Temporary Disability Benefits Law.

13. All books and records of the employer containing information pertinent to this insurance shall be open to examination by the Company during the policy term and within one year after the termination of this policy.

IN WITNESS WHEREOF, The LIFE INSURANCE COMPANY OF NORTH AMERICA has caused this policy to be signed by its President and Secretary at Philadelphia, Pennsylvania, and countersigned by a licensed resident agent of the Company.

Secretary,

G. Scott Kern, Corporate Secretary

President,

Matthew G Manders, President

Countersigned.....

Licensed Resident Agent

No. SDJ. 960664

APPLICATION TO
Life Insurance Company of North America

For

Group Disability Policy Insuring Under New Jersey Temporary Disability Law

To the Life Insurance Company of North America, Two Liberty Place, 1601 Chestnut Street, Philadelphia, Pennsylvania 19192: Based on the statement set forth below, the undersigned hereby applies for a group disability policy to include benefits in accordance with the private plan established by the undersigned pursuant to the New Jersey Temporary Disability Benefits Law.

Item 1. Name of Employer: Med Trans Corporation

Address: 209 State Highway 121 Bypass Suite 21 Lewisville, TX 75067

Business: Transportation

Item 2. All classes of employees subject to the New Jersey Temporary Disability Benefits Law are to be insured under this policy,

except the following: N/A

Item 3. The total number of employees to be eligible for this insurance is 10 Ees of which 0 are women.

Item 4. The effective date of this policy shall be January 1, 2017, 12 midnight Eastern Time.

Item 5. Premium for this policy shall be computed at the rate of: $.51 per $10.00 of weekly gross benefit of the first $32,600 wages paid to each insured employee by the employer during each calendar year.

Item 6. Previous group disability insurance carrier: UNUM

When and why terminated? Carrier Change

Dated at 209 State Highway 121 Bypass, Suite 21, Lewisville, TX 75067 the 28th day of October, 2016

Employer Signature: Brenda K Babb

Title: AMGH Benefits Manager

ORIGINAL TO BE SUBMITTED TO THE DIVISION OF TEMPORARY DISABILITY INSURANCE PO BOX 957 TRENTON, NEW JERSEY 08625-0957	DP-1 (R-01-12) STATE OF NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT DIVISION OF TEMPORARY DISABILITY INSURANCE **APPLICATION FOR** **APPROVAL OR MODIFICATION OF INSURED PRIVATE PLAN**	**45-0439149** New Jersey Employer Identification No. _____ Private Plan No.

1. ☐ **Approval** is requested for an insured Private Plan

CHECK ONE { } to provide New Jersey Temporary Disability Benefits

☒ **Modification** is requested for the insured Private Plan indicated above

effective **1/1/17**, as described below and in accordance with the details attached for the employees of:
Med Trans Corporation, **972-829-8350** *(Telephone Number)*
(Name of Employer, exactly as registered with the Department of Labor and Workforce)
209 State Highway 121 Bypass, Ste 21 Lewisville, TX 75067
(Address)

2. The policyholder, if other than employer named in Item 1 above, will be:

Air Medical Group Holdings, Inc.
(Policy Holder Name)

209 State Highway 121 Bypass, Ste 21 Lewisville, TX 75067
(Address)

3. Any and all notices, order, or communications **to the employer** may be served by mail, addressed to the following designated person as the duly authorized representative of the above-named employer:

Air Medical Group Holdings, Inc., Brenda Babb, 972-829-8350 *(Telephone No.)*
(Employer Representative, Title)
209 State Highway 121 Bypass, Suite 21 Lewisville, TX 75067
(Address)

4. The Plan will cover:

(a) ☒ All covered employees of the employer. Number of New Jersey employees: **10**

(b) ☐ Other (describe classes covered) _____

If more space is required, attach sheet.

Form DP-1A must be attached for excluded classes.

5. The contributions required of employees covered by the Private Plan will be:

CHECK ONE
(a) ☐ Statutory percentage of taxable wages, *(amount set annually by Law)*
(b) ☐ Other _____% of statutory taxable wage base *(must be less than statutory)*
(c) ☒ None. Employees were informed on **12/15/2016** that no deductions would be taken for New Jersey Temporary Disability Benefits.

Method used: 1. ☐ Written Notice 2. ☒ Verbal Notice 3. ☐ Bulletin Board Notice
4. ☐ Other _____

6. Employees' election: Employees' agreement to establishment or modification of the Plan (**Required** if employees contribute to the cost of the Plan, unless, in the case of a modification, such modification does not include either a reduction in the amount or duration of benefits or an increase in the rate of employee contributions.)

(a) Date election was held: _____
(b) Total number of employees required to contribute to the Private Plan: _____
(c) Number of employees in Line (b) agreeing to the Private Plan: _____

The original records of the election are submitted with this application.
(After being recorded by the Division of Temporary Disability Insurance, they will be returned to the employer, who shall retain them during the existence of the Plan and make them available for inspection by any authorized representative of the Division.)

7. The benefits provided by the Plan, payable in accordance with the details attached, will be as follows: (If more space is required, attach sheet.)

(a) Weekly Rate	(b) Limitations	(c) Eligibility Requirement
☒ Statutory	☒ All provided by NJSA 43:21-39 of the NJ Temporary Disability Benefits Law	20 Base weeks or 1000 times the State minimum wage invoked.
☐ Other (list) _____	☐ Other	☒ Yes ☐ No

(d) Duration of Benefits. The maximum duration of benefits for any individual will be:

(1) ☒ The lesser of 26 times the weekly benefit amount or 1/3 total wages in base year.

CHECK ONE { (2) ☐ 26 weeks for each period of disability.

(3) ☐ Other (describe) _____

(e) When Benefits commence. Benefits for each period of disability will commence:

(1) ☒ On the eighth day with respect to either accident or sickness. (**Note:** If benefits are payable for three or more consecutive weeks then the first seven days become payable.)

CHECK ONE { (2) ☐ On the first day with respect to any period of disability.

(3) ☐ Other (describe) _____

(f) Guaranteed Minimum Benefits. Anything in this Plan to the contrary not withstanding, the benefits payable to any employee for any period of disability commencing while insured hereunder, shall not be less than the employee would have been entitled to receive for such period under Article III of the NJ Temporary Disability Benefits Law, but for the employee's coverage under this Plan.

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8. The undersigned employer agrees to the establishment of the above Private Plan in accordance with the New Jersey Temporary Disability Benefits Law.

(Note: Pursuant to the NJAC 12:18-2.9(b), if an employer provides disability benefits through a multi-benefit plan that does not comply with the New Jersey Temporary Disability Benefits Law, the employer shall establish a separate plan, maintained solely for the purpose of complying with the provisions of the Law.)

Employer's Signature:

Signature: _____

Date: 10/31/2016

Title: Chief Financial and Administrative Services Officer

Must be: *(Owner, Partner, or Corporate Officer; Pres., V.P., Secy., Treas.)*

Printed Name: Michael Preissler

FOR INSURANCE COMPANY USE

9. Insurer's Agreement:

The undersigned insurer **agrees**, upon approval by the Division of Temporary Disability Insurance of the New Jersey Department of Labor and Workforce Development, to insure the Private Plan described in this application and accompanying details,to pay the benefits referred to in Item 7 of this application, to furnish any required documentation to the Division, and to furnish a policy of insurance consistent with the provisions of the approved Private Plan. A copy of the completed policy will be submitted to the Division of Temporary Disability Insurance within **forty-five (45)** days of the date of approval of this application.

Notice of assessments made against the employer

☒ should

☐ should not

be mailed to the insurer

Any and all notices, orders, or communications to the insurer should be mailed to:

Sherry i Brown
(Name)

Contract Senior Associate
(Title)

2 Liberty Place, Phila PA 19192
(Address)

Cigna - Lovo
(Name of Insurer)

Date Signed: 12/7/16

Signature: _____
(Insurer's Authorized Representative)

Title: Director

LIFE INSURANCE COMPANY OF NORTH AMERICA
ENDORSEMENT #1

Part I. Benefits is amended as follows:

1. Employee contributions are not required.

Effective Date: January 1, 2017
Issued to: Med Trans Corporation

Policy No: SDJ960664

President

LG-5134a

NOTICE OF YOUR EMPLOYER'S NEW JERSEY TEMPORARY DISABILITY BENEFITS PLAN

Insured By New Jersey Temporary Disability Benefits Policy issued to

Employer: Med Trans Corporation

Employer Registration No.: 45-0439149 Private Plan No.: 199-70607

by the

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PENNSYLVANIA

This plan provides the benefits described below, for each period that an insured employee is disabled. The benefits payable to the insured employee are in the same amount and for the same duration as such insured employee would receive if covered by the State Plan (The New Jersey Temporary Disability Benefits Law, as defined in Article 111, and limited in Section 6).

ELIGIBILITY

Effective January 1, 2017 you will not be eligible unless you have either:

a) earned at least $168 per week for 20 total weeks; or
b) earned at least $8,400

within the 52 weeks before the week you became disabled. You will not be eligible if you have been unemployed for 2 weeks or more.

CONTRIBUTIONS

You will not be required to contribute more than 0.24% of the first $33,500 of your wages during 2017.

DISABILITY OPTIONS

If you become disabled while you are covered, we will pay 2/3 of your average weekly wage. We will not pay more than:

a) $633 per week during 2017; and
b) After that, 53% of the statewide average weekly wage in the previous year, as set by the Commissioner of Labor and Workforce Development.

We will pay 1/7 of this amount for each day of a partial week that you are disabled, with the total rounded down to the nearest dollar.

You will be deemed "disabled" if you cannot do all the duties of your job.

We will pay this benefit until the first of these things happens:

a) We have paid benefits for 26 weeks; or We have paid 1/3 of your total wages (rounded down to the nearest dollar) earned in the 52 weeks before you became disabled; or
b) You are no longer disabled.

We will treat several periods of disability as one period, if:

a) They are due to the same or related causes; and
b) They are separated by less than 14 days.

To figure your "average weekly wage":

1) Add up your total wages for each of the last 8 weeks before you became disabled. After January 1, 2017, do not count any week that you earned less than $168.
2) Divide this sum by the number of weeks you counted. This is your "average weekly wage."
3) If it gives you a higher average, you may only count those weeks that you worked for your present employer.
4) If the above computation is less than your average weekly earnings in employment with all covered employers during the 26 calendar weeks before you became disabled, then the “average weekly wage” will be based on earnings from all covered employers during those 26 calendar weeks.

LIMITATION ON BENEFITS

Waiting Week - We will not pay benefits for the first 7 straight days that you are disabled. This does not apply if you are disabled:

a) for at least 3 straight weeks more; or
b) for at least 26 total weeks for that disability.

Other Compensation - If you receive any other money from your employer while you are disabled, we will not pay more than your weekly wage right before you were disabled, minus any such money paid by your employer.

Exclusions - We will not pay benefits:

a) While you are not under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse, certified nurse midwife, or chiropractor, who, when requested by the division, shall certify within the scope of the practitioner's practice, your disability, the probable duration thereof, and, where applicable, the medical facts within the practitioner's knowledge; or
b) If you become disabled as a result of injury to yourself done by you on purpose; or injury received while you were committing a crime of the first, second, third, or fourth degree; or for any period during which you would be disqualified for unemployment compensation benefits for gross misconduct under subsection (b) of R.S.43:21-5; or
c) While you are doing any work for wage or profit; or
d) If you were disqualified for unemployment compensation (under Section 43:21 - 5(d), of the New Jersey Revised Statutes) before you became disabled; or
e) If the weekly amount which together with any remuneration you continue to receive from the employer exceeds regular weekly wages immediately prior to disability.

NON-DUPLICATION OF BENEFITS

We will not pay benefits for any period for which you get or may claim benefits from any of the sources listed below.

a) Any unemployment compensation or similar law.
b) Any disability or cash sickness benefit or similar law.
c) Any Workers Compensation Law or occupational disease law, except for benefits for a permanent partial or total disability which you suffered previously. In case any such benefits are awarded for a period for which we paid you these benefits, then we shall receive your rights to such award, up to the amount that we paid.

Exceptions to the provision above: We will reduce the amount paid or payable under the Temporary Disability Benefits Law by the benefits payable by these programs if a claimant is eligible for or receiving benefits under:

a) a disability benefit law of another state; or
b) a disability or cash sickness program known as maintenance and cure as provided under the federal maritime law commonly referred to as the Jones Act.

Any benefits that we pay will be reduced by amounts paid at the same time by any retirement, pension or permanent disability benefit plan or allowance program to which your employer contributed on your behalf. This applies to both government and private plans.

PAYMENT OF CLAIMS

Notice of Claim - If you become disabled, you (or someone on your behalf) must send us written notice within 30 days, or as soon after that as is reasonably possible. This notice should include your name, your employer's name and policy number. Send this notice to us at our home office in Philadelphia, Pa., or to an agent authorized by us. We will then send you claim forms.

Proof of Loss – When we receive notice of claim, the Insurance Company will send claim forms for filing proof of loss. Proof of loss must be sent back to us not more than 90 days after the end of a covered period of disability, or as soon after that as is reasonably possible. We will send claim forms to you within 15 days of receipt of your notice of claim. If you do not receive the claim forms, you can meet the proof requirements by submitting, within the time required, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss. This proof must include written proof of the occurrence, type and amount of the loss.

Payment of Claims - We will pay benefits when we receive due proof of loss. Benefits will be paid every week, every 2 weeks, or as often as you are usually paid by your employer. Any amount due at the end of the covered period will be paid as soon as we receive due proof of loss.

We will pay you if you are living. Otherwise, we will pay your spouse or civil union partner (including a civil union partner in a same-sex relationship from another jurisdiction that provides substantially all of the rights and benefits of marriage), if living. Otherwise, we will pay your estate.

Physical Examinations - We may have you examined as often as reasonably necessary while a claim is pending, but not more than once a week.

Legal Actions - You may not sue for benefits less than 60 days nor more than 3 years after the date claim forms are due. This does not affect in any way your right of appeal under the New Jersey Temporary Disability Benefits Law. If you cannot agree with your employer or us as to the benefits we will pay, you may file a complaint in writing within 1 year after the start of the period for which you are claiming benefits. Complaints must be sent to:

N.J. Department of Labor and Workforce Development, Division of Unemployment and Temporary Disability Insurance, Disability Insurance Services
P.O. Box 957
Trenton, New Jersey 08625-0957

THIS NOTICE MUST BE POSTED CONSPICUOUSLY
AND CONTINUOUSLY AT THE EMPLOYER'S PLACE OF BUSINESS

LIFE INSURANCE COMPANY OF NORTH AMERICA
ENDORSEMENT #2

It is hereby understood and agreed that the Poster Notice for this Private Plan is amended as follows:

1. You are not required to contribute toward the cost of your insurance.

Effective Date of Coverage: January 1, 2017 Policy No: **SDJ960664**

Issued to: Med Trans Corporation

President

LG-5134a

PRIVATE PLAN NO.
199-70607

State of New Jersey
Department of Labor &
Workforce Development
Division of
Temporary Disability Insurance
Private Plan Operations

EMPLOYER IDENTIFICATION NO.
0450439149-000-00

CERTIFICATE OF MODIFICATION OF PRIVATE PLAN

This is to certify that Private Plan No. ***199-70607*** approved for:

Med Trans Corporation
209 State Highway 121 Bypass, Suite 21
Lewisville, TX 75067

has, on the basis of a notification received December 20, 2016
been modified as to the:

[ ] Contribution provisions

[X] Benefits provisions

[ ] Classes of workers covered

[X] Insurer

[ ] Other provisions of the plan ( )

effective January 1, 2017.

THIS PRIVATE PLAN COVERS: All employees.

DIVISION OF TEMPORARY DISABILITY INSURANCE

Ronald L. Marino
Assistant Commissioner

Date: January 5, 2017

By: _____

William C. Kampe Jr., Examiner

cc: Life Insurance Company of North America-Attn: Sherry I. Brown

DP-5C