K&K INSURANCE
SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

STUDENT OR ATHLETE ACCIDENT CLAIM FORM

Excess Coverage
K-12 ACCOUNTS

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 Fax: 312-381-9077 California License #0334819
email:kk.PAClaims@kandkinsurance.com
www.kandkinsurance.com

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: _____ First: _____ MI: _____
2. Date of Birth: _____ SS# _____ Sex: ☐ Male ☐ Female
3. Student's grade in school: _____ Email address: _____
4. Home Address Street: _____
   City: _____ State: _____ Zip: _____
   Parent(s)/Guardian(s) Home Phone: _____
5. Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM
   Nature of Injury: _____ Describe exactly how accident happened: _____
   _____
6. Nature of activity and location during which the injury occurred (check all boxes which apply):

O Pre-Kindergarten	O Elementary School	O Middle School
O High School	O Cafeteria	O Classroom Activities
O Interscholastic Sports	O Intramural Sports, *name of sport, if applicable:* _____	
O Club Sports	O Physical Education Class	O Other Activity (specify) _____
O During Practice	O During Play	O During Travel To or From the Event

   Nature of Your Participation:

O Student	O Volunteer	O Student/Manager
O Athletic Participant	O Cheerleader	O Band Member

   O Other (specify) _____
7. Transfer Student? O Yes O No
   If yes, please identify the former school name: _____
8. Name, address and phone number of physician who first treated you: _____

9. Have you had a similar injury in the past? **O** Yes **O** No

   If yes, describe and give dates: _____

10. Name, address and phone number of physician who treated you for previous injury: _____

11. Are you covered by any other medical expense benefits plan? **O** Yes **O** No

    If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date _____ Parent/Guardian Signature _____

SECTION II (TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Student's Name Last: _____ First: _____ MI: _____
2. Date of Accident _____
3. Activity _____
4. Nature of Injury _____
5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT _____
6. Name of participating SCHOOL _____
7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

   SIGNATURE OF SCHOOL OFFICIAL: _____

   PRINTED NAME/TITLE: _____

   PHONE: _____ FAX: _____

   EMAIL: _____ DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files forms 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.

Date _____ Policyholder (School Official) Signature _____

IMPORTANT NOTICE

• In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia: 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.

• For Residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.

• 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 the District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

• **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 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 Maine, Tennessee 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 include imprisonment, fines and denial of insurance benefits.

• For residents of Oregon: Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

• For residents of Maryland: Any person who knowingly of 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 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 and 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: 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 Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

• **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.

• For residents of Texas: 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.

• For residents of Virginia: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

[AXIS_FRAUD 0220]

Dear Participant: If you have an appointment with a doctor as a result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates.

The First Health Network

HYGEIA

PHCS

INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT/GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT O Yes O No

EMANCIPATED STUDENT: O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No

NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? O Yes O No	IS MOTHER DECEASED? O Yes O No
IS FATHER LEGALLY RESPONSIBLE? O Yes O No	IS MOTHER LEGALLY RESPONSIBLE? O Yes O No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No	EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: ( ) _____	PHONE: ( ) _____
CONTACT PERSON: _____	CONTACT PERSON: _____
Do you have group medical insurance coverage through your employment? O Yes O No	Do you have group medical insurance coverage through your employment? O Yes O No
If Yes, is it: O Individual O Family	If Yes, is it: O Individual O Family
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)	TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)
O PREFERRED PROVIDER ORGANIZATION (PPO)	O PREFERRED PROVIDER ORGANIZATION (PPO)
O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE	O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES
O OTHER (describe) _____	O OTHER (describe _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____ PARENT/GUARDIAN/MOTHER SIGNATURE: _____

DATE: _____ DATE: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPOECT TO THE ACCIDENTAL, INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

KAMV0000018070004

Underwritten by:
AXIS Insurance Company
Serviced by:
K&K Insurance Group, Inc.

MANDATORY & VOLUNTARY BLANKET MASTER INSURANCE APPLICATION

Coverage not available in the following states: AR, MD, NH, NY, WA

Application is hereby made for a plan of BLANKET ACCIDENT INSURANCE based on the following statements and representations:

Policyholder: Name of School/District: BEECH GROVE CITY SCHOOLS

Requested Effective Date: 08/01/2025 Requested Termination Date *(one year from the Requested Effective Date)*: 08/31/2026

Street Address: 5334 HORNET AVE.

City: BEECH GROVE State: IN Zip: 46107

Mailing Address (If different):

Contact Name: Title:

Phone: Fax:

Email:

Mandatory Accident Coverage *(Coverage selected by school/district)*

	Product Option	*Grades*	*Total # of Insured*	*Rate*	*Premium*
At-School Including Athletics & Activities					
At-School Excluding Athletics & Activities					
Athletics & Activities					
Field Trip					
School Band					
JROTC					
Other (Please Specify)					
Other (Please Specify)					
Other (Please Specify)					
			Total Mandatory Premium Due:		

Voluntary Accident Coverage

Estimated annual school enrollment *(total number of students):*

Grades *(mark one):* [X] PK-12 [ ] Elementary School [ ] Middle School [ ] High School

Effective Date: 08/01/2025

The terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. The terms of the policy when issued will govern. It is agreed the insurance applied for will not become effective unless a) this application is received and approved by AXIS Insurance Company based on current rules and requirements; b) the policy is accepted by the applicant; and c) the required premium is paid when due.

The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.

POLICYHOLDER SIGNATURE

Authorized Signature of Applicant

Printed or typed name of Applicant's Authorized Representative

Date

LICENSED BROKER/AGENT SIGNATURE

Licensed Broker/Agent

License Number

Date

IMPORTANT NOTICE - FRAUD WARNING

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** 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.
- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ***For residents of California***: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***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 the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***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 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 Maine, Tennessee 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 include imprisonment, fines and denial of insurance benefits.
- ***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 New Hampshire***: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- ***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:*** 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 Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the

IMPORTANT NOTICE - FRAUD WARNING

proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Oregon:*** Any person who knowingly and 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 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.
- ***For residents of Texas:*** 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.
- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

BLANKET ACCIDENT POLICY/CERTIFICATE

Underwritten by:
AXIS INSURANCE COMPANY
(A Stock Company)
(Herein called the Company)

Administrative Office:
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009

Home Office:
111 South Wacker Drive, Suite 3500
Chicago, IL 60606

POLICYHOLDER: BEECH GROVE CITY SCHOOLS

POLICY EFFECTIVE DATE: 08/01/2025

POLICY NUMBER: KAMV0000018070004

POLICY TERM: 08/01/2025 through 08/31/2026

POLICY ANNIVERSARY DATE: 08/01

STATE OF ISSUE: Indiana

The Policy is a legal contract between the Policyholder and the Company.

This Policy describes the terms and conditions of insurance. This Policy/Certificate goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date shown above at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Policy/Certificate terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy/Certificate for an additional Policy Term. The laws of the State of Issue shown above govern this Policy/Certificate.

The Company and the Policyholder agree to all the terms of this Policy/Certificate.

Secretary

President

THIS IS A LIMITED POLICY
IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS
THIS POLICY MAY CONTAIN A DEDUCTIBLE
PLEASE READ IT CAREFULLY
NON-PARTICIPATING

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL THE POLICY PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the Conditions of Coverage and Description of Benefits sections for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

	Principal Sum
Class 1 Students on whose behalf the required premium contribution is made for Low Option 24-Hour coverage	$10,000
Class 2 Students on whose behalf the required premium contribution is made for High Option 24-Hour coverage	$10,000
Class 3 Students on whose behalf the required premium contribution is made for Low Option Summer Only coverage	$10,000
Class 4 Students on whose behalf the required premium contribution is made for High Option Summer Only coverage	$10,000
Class 5 Students on whose behalf the required premium contribution is made for Low Option At-School coverage	$10,000
Class 6 Students on whose behalf the required premium contribution is made for High Option At-School coverage	$10,000
Class 7 Student Members of the high school football team on whose behalf the required premium contribution is made for full football season Low Option coverage	$10,000
Class 8 Student Members of the high school football team on whose behalf the required premium contribution is made for full football season High Option coverage	$10,000
Class 9 Student Members of the high school football team on whose behalf the required premium contribution is made for spring football Low Option coverage	$10,000
Class 10 Student Members of the high school football team on whose behalf the required premium contribution is made for spring football High Option coverage	$10,000

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages:

Classes 1 & 2

24-HOUR COVERAGE

Covered Activities:	All activities excluding high school football
Personal Deviations Covered	**No**
Covered Travel	**Included**
Covered Overnight Travel	**Included**

Classes 3 & 4

24-HOUR COVERAGE

Covered Activities:	All activities between the last day of the school year commencing during the policy period and the first day of the following school year
Personal Deviations Covered	**No**
Covered Travel	**Included**
Covered Overnight Travel	**Included**

Classes 5 & 6

SCHOOL COVERAGE

Covered Activities:	Participating in or attending any Policyholder sponsored activity, excluding high school football, or while traveling to or from the Insured Person's residence and the Policyholder's premises on days when the Insured Person has regularly scheduled classes or at any other time if traveling by transportation furnished or approved by the Policyholder
Personal Deviations Covered	**No**
Covered School Travel	**Included**
Covered Overnight Travel	**Included**

Classes 7, 8, 9 & 10

SPORTS COVERAGE

Covered Activities:	Practice or play of high school football in accordance with the rules of the state high school athletics authority. Group or team travel supervised by the Policyholder to or from a practice or play is covered if in a vehicle furnished or approved by the Policyholder.
Personal Deviations Covered	**No**
Covered Sports Travel	**Included**
Covered Overnight Travel	**Included**
Sports Organization:	**The Policyholder**

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
Accidental Death and Dismemberment	$500,000

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. This Aggregate Limit of Indemnity is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within	365 days of the Covered Accident
Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in Both Ears)	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in Both Ears)	50% of the Principal Sum
Loss of Hearing in One Ear	25% of the Principal Sum
Loss of Thumb and Index Finger of the same Hand	25% of the Principal Sum
Exposure and Disappearance	**Included**

ACCIDENT MEDICAL BENEFIT

Scope of Coverage Applicable to Accident Medical Benefits
Any benefit limits and benefit percentages apply, unless otherwise specified, on a per Insured Person – per Covered Loss basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

Other Health Care Plan Reduction	0%
Total Maximum for all Accident Medical Benefits	Class 1 - $25,000 Class 2 - $25,000 Class 3 - $25,000 Class 4 - $25,000 Class 5 - $25,000 Class 6 - $25,000 Class 7 - $25,000 Class 8 - $25,000 Class 9 - $25,000 Class 10 - $25,000
First Covered Expenses must be incurred within	60 days after the Covered Accident
Benefit Period	52 weeks from the date of the Covered Accident
Deductible	Class 1 - $0 Class 2 - $0 Class 3 - $0 Class 4 - $0 Class 5 - $0 Class 6 - $0 Class 7 - $0

	Class 8 - $0 Class 9 - $0 Class 10 - $0
Deductible applies to	each Covered Accident
Deductible must be satisfied within	52 weeks from the date of the Covered Accident

Classes 1, 3, 5, 7 & 9

Covered Expenses	**Benefit Percentage and Other Limits**
Determination of the amount of each Covered Expense, and where applicable, each Usual and Customary Charge, will be made solely by the Company.	
Expanded Medical Benefit For Covered Sports Conditions	100% of Usual and Customary Charges
Covered Sports Conditions	bursitis; sprains; hernia; muscle tears; tendonitis; and repetitive motion injuries
Heart and Circulatory Conditions	100% of Usual and Customary Charges
Covered Heart and Circulatory Conditions	heat exhaustion; heart attack; cardiac arrest, stroke; burst aneurysm
Inpatient Hospital Services Room and Board Expenses Semi-Private Room	 Up to $150 per day
Miscellaneous Expenses Physician's Visits (limited to one visit per day)	$600 maximum per day $40 first day/$25 each subsequent day
Ambulatory Medical Center	$1,000 maximum
Emergency Room Treatment (treatment must be rendered within 72 hours from the time of the injury)	$150 maximum
Surgery	$1,000 maximum
*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.	
Assistant Surgeon	100% of Usual and Customary Charges
*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.	
Anesthesia and its Administration	100% of Usual and Customary Charges
*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.	
Outpatient Physician Visits (limited to one visit per day)	$40 first day/$25 each subsequent day
Outpatient X-ray	$200 maximum
Outpatient Diagnostic Imaging Services	$300 maximum
Outpatient Laboratory	$50 maximum
Outpatient Physiotherapy (limited to one visit per day) (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	$30 first day/$20 each subsequent day, 5 day maximum
Ambulance Services (Air and Ground)	$300 maximum
Medical Equipment Rental (Includes Orthopedic devices)	$75 maximum
Dental Services	$10,000 maximum per policy term
Prescription Drugs	$75 maximum
Consultant	$200 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids	100% of Usual and Customary Charges

Classes 2, 4, 6, 8 & 10

Covered Expenses	**Benefit Percentage and Other Limits**
Determination of the amount of each Covered Expense, and where applicable, each Usual and Customary Charge, will be made solely by the Company.	
Expanded Medical Benefit For Covered Sports Conditions	100% of Usual and Customary Charges
Covered Sports Conditions	bursitis; sprains; hernia; muscle tears; tendonitis; and repetitive motion injuries
Heart and Circulatory Conditions	100% of Usual and Customary Charges
Covered Heart and Circulatory Conditions	heat exhaustion; heart attack; cardiac arrest, stroke; burst aneurysm
Inpatient Hospital Services Room and Board Expenses Semi-Private Room	 80% of Usual and Customary Charges
Miscellaneous Expenses Physician's Visits (limited to one visit per day)	$1,200 maximum per day $60 first day/$40 each subsequent day
Ambulatory Medical Center	$1,200 maximum
Emergency Room Treatment (treatment must be rendered within 72 hours from the time of the injury)	$300 maximum
Surgery	$1,200 maximum
*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.	
Assistant Surgeon	100% of Usual and Customary Charges
*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.	
Anesthesia and its Administration	100% of Usual and Customary Charges
*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.	
Outpatient Physician Visits (limited to one visit per day)	$60 first day/$40 each subsequent day
Outpatient X-ray	$600 maximum
Outpatient Diagnostic Imaging Services	$600 maximum
Outpatient Laboratory	$300 maximum
Outpatient Physiotherapy (limited to one visit per day) (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	$60 first day/$40 each subsequent day, 5 day maximum
Ambulance Services (Air and Ground)	$800 maximum
Medical Equipment Rental (Includes Orthopedic devices)	$140 maximum
Dental Services	$10,000 maximum per policy term
Prescription Drugs	$200 maximum
Consultant	$400 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids	100% of Usual and Customary Charges

PREMIUM RATE TABLE

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Cancellation and Premium Rate Change sections of the Administrative Provisions of this Policy.

Mode of Premium Payment	Annually
Premium Due Date	Policy Effective Date
Initial Premium	As per the Master Insurance Application

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place.

Aircraft means a vehicle which:

1. has a valid Airworthiness Certificate; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Airworthiness Certificate means a “Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

Calendar Year means January 1st through December 31st of any year.

Common Carrier or Public Conveyance means:

1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means an Accident that results in a Covered Loss during the Policy Term.

Covered Activity or Covered Activities means any activity that is shown in the *Schedule of Benefits* and:

1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits;* and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

Covered Expenses means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Covered Injury means Accidental bodily injury: (1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body, and (2) which results directly and independently from all other causes from a Covered Accident. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Covered Loss means a loss which meets the requisites of one or more benefits, and results from a Covered Accident, Covered Injury or Covered Activity.

Eligible Person means an individual as defined in the *Schedule of Benefits*.

He, His, Him refers to any individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and

6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

Hospital Confined, Hospital Stay or Confined to a Hospital means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 30 days.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, domestic partner, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Inpatient means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.

Insured Person means an Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Medically Necessary means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order.

Nurse means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household; or
4. a person employed or retained by the Policyholder.

Outpatient means an Insured Person who is a patient and is not hospitalized overnight but who visits a Hospital, clinic, or associated facility for diagnosis or treatment.

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder means the entity, named on this Policy's face page, to which the Company issues this Policy.

Policy Term means the time period defined for the Policyholder shown on this Policy's face page.

Private Passenger Automobile	means a validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other Public Conveyance will not be considered a Private Passenger Automobile.
Scheduled Airlines or Aircraft	means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.
Spouse	means the Insured Person's lawful spouse.
Usual and Customary Charge	means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.
We, Us, Our	means AXIS Insurance Company.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Effective Date for Individuals

Insurance becomes effective for the Eligible Person who enrolls and agrees to make the required contributions on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Eligibility

A person is eligible for insurance under this Policy when He meets the definition of Eligible Person shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one covered class, even though He may be eligible under more than one covered class.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such changes.

Policy Effective Date

The Company agrees to provide Accident insurance benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Termination of Insurance

Insurance for the Insured Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class;
2. the end of the period for which the last premium is made; or
3. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable benefit limit or maximums, as shown in the *Schedule of Benefits*, have been paid.

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. injuries compensable under Workers' Compensation law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
14. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
15. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;
    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
    d. the Insured Person.

LIMITATIONS

Pre-Existing Condition Limitation

Benefits under this Policy are not payable in connection with a Pre-Existing Condition for a period ending 90 day(s) after the Insured Person's effective date of coverage under this Policy.

A Pre-Existing Condition means:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 90 day period immediately preceding the effective date of coverage under this Policy;

(2) a condition for which medical advice, diagnosis, care or treatment was recommended or received by the Insured Person in the 90 day period immediately preceding the effective date of coverage under this Policy; or

(3) a pregnancy existing on the effective date of coverage under this Policy.

CLAIM PROVISIONS

Beneficiary

If more than one person is named as beneficiary, the interests of each will be equal unless the Insured Person has specified otherwise. The share of any beneficiary who does not survive the Insured Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Insured Person dies while benefits are payable to Him, the Company may make direct payment to the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the Insured Person.

Claim Forms

The Company or its designated authorized agent will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Policyholder's name and the Policy Number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Notice of Claim

Written notice of claim must be given to the Company or its designated authorized agent within 30 days after the occurrence or commencement of the Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company or its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

Payment of Claims

All benefits will be paid in United States currency. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Provision and these Claim Provisions.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to His beneficiary as described in the Beneficiary Provision.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Conditional Claim Payment

If the Insured Person incurs expenses for Covered Injuries and in Our opinion a third party may be liable, the Company will pay benefits if the Insured Person first agrees in writing to refund the lesser of:

1. the amount the Company actually paid for such expenses; and
2. the amount actually received from the third party, regardless of whether the amount is for such expenses, and the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under this Policy, the Company will pay the difference.

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished under this Policy.

Physical Examination And Autopsy

The Company, at its own expense, has the right and opportunity to examine the Insured Person when and as often as the Company may reasonably require while a claim is pending and to make an autopsy in case of death, where it is not prohibited by law.

Proof of Loss

Written proof of loss must be furnished to the Company within 365 days after the date of the Covered Loss. In the case of a claim for loss of time for disability, written proof of such loss must be furnished to the Company within 365 days after the commencement of the period for which the Company is liable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as may reasonably be required. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to furnish 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 claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

Subrogation

The Company has the right to recover all payments including future payments, which the Company has made, or will be obligated to pay in the future, to the Insured Person from anyone liable for the Covered Loss. If the Insured Person recovers from anyone liable for the Covered Loss, the Company will be reimbursed first from such recovery to the extent of the Company’s payments to the Insured Person. The Insured Person agrees to assist the Company in preserving its rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by the Company.

ADMINISTRATIVE PROVISIONS

Cancellation

The Company or the Policyholder may cancel this Policy after the first year or Policy Term or as of any Premium Due Date, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Policyholder's right to cancel this Policy.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Premium Rate Table.

Cancellation does not affect a claim for a Covered Loss when the Covered Accident occurs before the cancellation date.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the first Premium Due Date. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the Premium Due Date and in accordance with the terms of this Policy. If the required premium is not paid during the grace period, coverage will terminate on the last day of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The Company will provide notifications of premiums due or premium changes, to the most current address in Our files, to the Policyholder.

Premium Payment

The total premium paid by the Policyholder is the sum of premiums for all Insured Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the Premium Rate Table, unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's Home Office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.

Premium Rate Changes

The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 31 days advance notice to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable premium rate guarantee period if any one of the following occurs:

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period; or
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Reinstatement

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Addition of New Insured Persons

All Insured Persons added to the Classes of Eligible Persons in the *Schedule of Benefits* are eligible for insurance under this Policy.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Certificates

Where required by law, the Company will provide a certificate of insurance for delivery to the Insured Person. Each certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, and to whom the insurance benefits are payable, and a statement as to any family member, Spouse or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

Clerical Error

A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

Conformity with Statutes

Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Entire Contract; Changes

The Policy and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person or, in the event of the death or incapacity of the Insured Person, to His beneficiary or personal representative.

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Examination of the Policy

This Policy will be available for inspection at the Policyholder's office during regular business hours.

Incontestability

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Misstatement of Fact

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

Policy Changes

No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the Policyholder to modify a plan of benefits without the Insured Person's consent.

Records

The Policyholder or its authorized administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable

time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

Reporting Requirements

The Policyholder or its authorized agent must report all of the following to the Company by the Premium Due Date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated; and
4. additional information required by the Company.

The Company may, at the Company's sole discretion, waive reporting of any information specified above.

Workers' Compensation

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations of coverage.

SPORTS COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs while He is participating in or attending one of the following sports Covered Activities:

1. regularly-scheduled high school football practice or training;
2. regularly-scheduled high school football competition or exhibition game;
3. a scheduled high school football tryout, workout session or team meeting;
4. a Supervised and Sponsored Sports Activity; or
5. Covered Sports Travel.

Covered Sports Travel includes travel, only within the contiguous United States including Alaska and Hawaii and only directly and without interruption:

1. between home and the premises of the Sports Organization;
2. between home and another meeting place designated by the Sports Organization;
3. between home and another site designated by the Sports Organization, where a Supervised and Sponsored Sports Activity is scheduled; or
4. between the premises of the Sports Organization or other meeting place it designates, and another site where a Supervised and Sponsored Sports Activity is scheduled.

Travel Coverage for Overnight Supervised and Sponsored Sports Activities
Covered Sports Travel also includes travel by any Common Carrier providing transportation to a Supervised and Sponsored Sports Activity, within the contiguous United States, including Alaska and Hawaii, when the Insured Person's participation or attendance requires Him to be away from His normal residence for a stay of one or more nights. Coverage for travel to any Supervised and Sponsored Sports Activity that takes place outside the contiguous United States, including Alaska and Hawaii will be covered only if the Company has agreed to it in writing.

Definitions

For purposes of this Condition of Coverage:

Covered Sports Travel means transportation on a Common Carrier or Private Passenger Automobile driven by an adult with a valid drivers' license whom the Sports Organization has specifically designated to transport Insured Persons to a Supervised and Sponsored Sports Activity.

Personal Deviation means

1. an activity that is not reasonably related to the Insured Person’s Covered Sports Travel;
2. not incidental to the purpose of the trip; and
3. such travel or activities coincide with the Insured Person’s Covered Sports Travel.

Sports Organization means a School, college or university, team, league or other organization, as named in the *Schedule of Benefits*, that organizes, sponsors, supervises, schedules or otherwise provides sports Covered Activities.

Supervised and Sponsored Sports Activity means a Covered Activity that:

1. takes place:
    a. on a Sports Organization’s premises during scheduled hours; or
    b. at another site at which the Covered Activity is scheduled;
2. is sponsored, organized or otherwise provided, by the Sports Organization; and
3. is supervised by a coach, referee, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the Sports Organization.

Exclusions

1. This coverage will not be in effect during any sports activity unless it is sponsored, organized, supervised, scheduled or otherwise provided by the Sports Organization named in the *Schedule of Benefits*.
2. This coverage will not be in effect during the Insured Person's Personal Deviation.
3. This coverage will not be in effect during travel to any Supervised and Sponsored Sports Activity that takes place outside the contiguous United States, including Alaska and Hawaii unless the Company has agreed in advance to provide it.

Other exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

SCHOOL COVERAGE

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs while He is participating in or attending one of the following School Covered Activities:

1. regularly-scheduled classroom instruction;
2. regularly-scheduled and supervised recess or lunch period;
3. a study period or special instruction period supervised by a member of the School's faculty;
4. a Supervised and Sponsored School Activity; or
5. Covered School Travel.

Covered School Travel includes travel, only within the contiguous United States including Alaska and Hawaii and only directly and without interruption:

1. between home and School;
2. between home and another meeting place designated by the School;
3. between home and another School or site designated by the School, where a Supervised and Sponsored School Activity is scheduled; or
4. between the School or other meeting place designated by the School, and another School or site designated by the School, where a Supervised and Sponsored School Activity is scheduled.

School Travel Coverage for Overnight Supervised and Sponsored School Activities

Covered School Travel also includes travel by any Common Carrier providing transportation to a Supervised and Sponsored School Activity, within the contiguous United States including Alaska and Hawaii and when the Insured Person's participation or attendance requires Him to be away from His normal residence for a stay of one or more nights. Coverage for travel to any Supervised and Sponsored School Activity that takes place outside the contiguous United States, including Alaska and Hawaii will be covered only if it has been agreed to by the Company in writing.

Definitions

For purposes of this Condition of Coverage:

Covered School Travel means transportation on a School bus or Private Passenger Automobile driven by a member of the faculty or staff of the School, a parent of the Insured Person, or other adult with a valid drivers' license whom the School has specifically designated to transport Insured Persons to a Supervised and Sponsored School Activity.

Personal Deviation means

1. an activity that is not reasonably related to the Insured Person's Covered School Travel;
2. not incidental to the purpose of the trip; and
3. such travel or activities coincide with the Insured Person's Covered School Travel.

Supervised and Sponsored School Activity means a Covered Activity that:

1. takes place:
   a. on School premises during, before or after normal School hours; or
   b. at another School or site at which the Covered Activity is scheduled; and
2. is sponsored, organized or otherwise provided, or at which student attendance is required, by the School; and
3. is supervised by a member of the faculty or staff of the School, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the School; or
4. is a regularly-scheduled sports tryout, practice, workout or training session, team meeting, game, exhibition play or competition in which the Insured Person is participating, excluding high school football.

Exclusions

1. This coverage will not be in effect during a School activity that was not a Supervised and Sponsored School Activity or Covered Activity during the preceding school year, unless the Company has agreed in advance to provide it.
2. This coverage will not be in effect during the Insured Person's Personal Deviation.
3. This coverage will not be in effect during travel to any Supervised and Sponsored School Activity that takes place outside the United States, including Alaska and Hawaii unless the Company has agreed in advance to provide it.

Other exclusions that apply to this Condition of Coverage are in the Common Exclusions Section.

24 HOUR COVERAGE (Classes 3 & 4 Summer Only)

The Company will pay the Benefit Amount shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs anytime while insured by this Policy including riding in or exiting an Aircraft.

Exclusions

This coverage will not be in effect while the Insured Person is participating in any activity including tryouts, practice or any competitions or games for high school football.

Other exclusions that apply to this Condition of Coverage are in the Common Exclusions section.

DESCRIPTION OF BENEFITS

This Description of Benefits Section describes the Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits*. Please read these and the Common Exclusions section in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Losses

The Company will pay the Benefit Amount for any one of the Covered Losses listed in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Insured Person suffers a loss as a result of a Covered Injury within the applicable time period specified in the *Schedule of Benefits*.

If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay the Benefit Amount for the Covered Loss for which the largest benefit is payable.

Exposure and Disappearance

If by reason of an Accident occurring while an Insured Person's coverage is in force under this Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which an Accidental Death or Accidental Dismemberment Benefit is otherwise payable under the Policy, the Covered Loss will be covered under the terms of this Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the Insured Person was an occupant while covered under this Policy, then it will be deemed, subject to all other terms and provisions of this Policy, that the Insured Person has suffered an Accidental Death that would have been payable under the Policy.

Definitions

For purposes of this Benefit:

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

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

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

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

Exclusions

Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENT MEDICAL BENEFIT

Medically Necessary Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits*. Medically Necessary Covered Expenses must be incurred within the Benefit Period shown in the *Schedule of Benefits*.

Other Health Care Plan Benefits

When any Other Health Care Plan provides benefits in the form of services rather than cash payments, the Company will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

Covered Expenses

The Company will pay the benefits shown in the *Schedule of Benefits* for Medically Necessary Covered Expenses incurred by the Insured Person, subject to all applicable conditions and exclusions, for treatment of a Covered Injury.

Benefits will be paid:

1. when Medically Necessary Covered Expenses incurred exceed any applicable Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits*;
2. as long as the first expense has been incurred within the number of days specified in the *Schedule of Benefits*;
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired;
4. until the total of Medically Necessary Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the *Schedule of Benefits*; and
5. until Benefits paid equal the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.

Expanded Medical Benefit For Covered Sports Conditions

The Company will pay Medically Necessary Covered Expenses incurred for the treatment of the Sports Conditions if they are aggravated by the Insured Person's participation in a Covered Activity.

Termination of Benefit
This Benefit will terminate at 12:01 A.M. Standard Time on the day after the team of which the Insured Person is a member has played its last game, including post-season tournament play.

Heart and Circulatory Conditions

The Company will pay Medically Necessary Covered Expenses incurred for the treatment of the Heart and Circulatory Conditions if they occur and are manifested during a Covered Activity.

Termination of Benefit
This Benefit will terminate at 12:01 A.M. Standard Time on the day after the team of which the Insured Person is a member has played its last game, including post-season tournament play.

Inpatient Hospital Services

Room and Board Expenses
The Company will pay for:

1. confinement in an intensive care unit for each day of such confinement; and
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses

The Company will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Miscellaneous Expenses include, but are not limited to: X-ray, laboratory, In-Hospital physiotherapy, Nurse services, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay

Ambulatory Medical Center

The Company will pay Medically Necessary Covered Expenses incurred for medical or surgical treatment provided in a licensed facility providing ambulatory surgical or medical treatment that is not a Hospital or Physician's office.

Emergency Room Treatment

The Company will pay Medically Necessary Covered Expenses incurred for Outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits*. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Medically Necessary Hospital Covered Expense.

Physician Services

The Company will pay Medically Necessary Covered Expenses incurred for Physician Services listed below.
Surgery –

1. Medically Necessary Covered Expenses charged for performing a surgical procedure. Two of more surgical procedures through the same incision will be considered as one procedure;
2. Medically Necessary Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure;
3. Medically Necessary Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the Outpatient department of a Hospital or an ambulatory surgical center; and
4. any braces, splints or other devices required after surgery to ensure proper healing.

Second Opinion or Consultation – Medically Necessary Covered Expenses charged by a Physician for a second surgical opinion, or consultation.

Anesthesia and its Administration – Medically Necessary Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Medically Necessary Covered Expenses charged by a Physician for other than pre- or post-operative care, second opinion or consultation:

1. for In-Hospital visits; and
2. for office visits.

Outpatient X-ray, CT Scan, MRI and Laboratory Tests

The Company will pay Medically Necessary Covered Expenses incurred for X-rays, except dental X-rays, CT Scans, MRI's, and laboratory tests.

Outpatient Physiotherapy

The Company will pay Medically Necessary Covered Expenses incurred for Outpatient Physiotherapy. Physiotherapy means acupuncture, microthermy, manipulation, diathermy, massage therapy, heat treatment, and ultrasonic treatment.

Ambulance Services

The Company will pay Medically Necessary Covered Expenses incurred for ground or air ambulance service to transport the Insured Person from the place where the Covered Accident occurred. The Company will pay Medically Necessary Covered Expenses incurred for ground or air ambulance transportation from the nearest medical facility to another appropriate medical facility, if a Physician specifies in writing that specialized care not available in the first facility to which the Insured Person was transported is necessary to treat His Covered Injuries.

Medical Equipment Rental

The Company will pay Medically Necessary Covered Expenses incurred for rental or, if less, purchase of:

1. a wheelchair or Hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Insured Person and that can only be used by the Insured Person. Permanent or temporary therapeutic value is solely determined by the Company. Examples of items that are not covered include, but are not limited to: computers, motor vehicles and modifications thereof, ramps, installation costs, eyeglasses and hearing aids.

Dental Services

The Company will pay Medically Necessary Covered Expenses incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps;
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Medically Necessary Covered Expenses include examinations, X-rays, restorative treatment, endodontics, oral surgery and initial braces required for treatment of a Covered Injury and treatment of gingivitis resulting from trauma.

If there is more than one way to treat a dental problem, the Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

The Company will pay the Medically Necessary Covered Expenses incurred for drugs that: (a) can only be obtained through a Physician's written prescription; and (b) are approved for such prescription use by the Federal Drug Administration (FDA). The Company will also pay Medically Necessary Covered Expenses incurred for drugs that meet all of the above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA. The Medically Necessary Covered Expense for a prescription drug is limited to the cost of a generic drug unless: (1) substitution of a generic drug is prohibited by law; or (2) no generic drug is available; or (3) the Insured Person's Physician specifically requests that a non-generic drug be dispensed to the Insured Person.

Definitions

For purposes of this Benefit:

Deductible means the amount of Medically Necessary Covered Expenses that must be paid by the Insured Person before benefits will become payable under this Policy. A separate Deductible shall apply to each Covered Accident. The Deductible shall be reduced by the amount of medical expenses paid or payable under an Other Health Care Plan for medical expenses arising out of the Covered Injury that gave rise to the claim under this Policy.

Heart and Circulatory means disease or illness of the heart or circulatory system which: (a) is first diagnosed and treated while the Insured Person's coverage under the Policy is in force and occurs in a scheduled game or supervised practice, within 24 hours after the participation; and (b) the Insured Person has not, before such participation, been medically advised of or received any medical treatment for such heart malfunction.

HMO – Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider of service.

Non-Preferred Provider means any Hospital, Physician, or other provider of health care services which is not a member of an HMO or PPO plan.

Other Health Care Plan or Other Health Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for healthcare, dental care, disability benefits or repatriations of remains. Any Other Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Providers Organizations and other prepayment, group practices and individual practice plans;
5. medical benefits provided under automobile "fault" and "no-fault" type contracts; and
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a) a state sponsored Medicaid plan; or

b) a plan or law providing benefits only in excess of any private or nongovernmental plan.

PPO – Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform these services at rates lower than Non-Preferred Providers.

Limitation for Contributory School and/or Sports Coverage

If benefits are payable for any Covered Loss under this Policy and under another blanket accident insurance policy issued by the Company for which the Policyholder pays the entire premium:

1. benefits will be payable first under that policy; and
2. the total benefits payable under both policies will not exceed the maximum benefit amount in the policy that provides the greater maximum.

EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses, unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. repair or replacement of existing artificial limbs, eyes and larynx;

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

Underwritten by:
AXIS INSURANCE COMPANY
111 S. Wacker Drive, Suite 3500
Chicago, Illinois 60606
(A Stock Company)

Administrative Office:
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009

Policyholder : BEECH GROVE CITY SCHOOLS
Policy Number : KAMV0000018070004
Effective Date of this (Rider) : 08/01/2025

NON-DUPLICATION OF BENEFITS

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It applies only with respect to a Covered Injury that occurs on or after that date.

The following provision is included in the **Schedule of Benefits**:

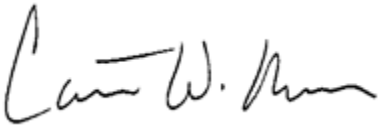
Non-Duplication of Benefits If the Covered Person is covered by Other Valid and Collectible Insurance, all benefits payable by such insurance will be determined before benefits will be paid by this Policy. This Policy is the second payor to any other insurance having primary status or no coordination or non-Duplication of benefits provision. If the Covered Person is insured under group or blanket insurance which is also excess to other coverage, this Policy pays a maximum of 50% of the benefits otherwise payable. Benefits paid by this Policy will not exceed: (1) any applicable Policy maximums: and (2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

Other Valid and Collectible Insurance means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for healthcare, dental care, disability benefits or repatriations of remains. Other Valid and Collectible Insurance includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Providers Organizations and other prepayment, group practices and individual practice plans;
5. medical benefits provided under automobile “fault” and “no-fault” type contracts; and
6. medical benefits provided by any governmental plan or coverage or other benefit law, except
   a) a state sponsored Medicaid plan; or
   b) a plan or law providing benefits only in excess of any private or nongovernmental plan.

The President and Secretary of AXIS Insurance Company witness this Rider:

Secretary



President

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103 Indianapolis, IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. “Protected health information” includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor’s office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers’ compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI
You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI
You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI
You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws
HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints
If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information
If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective March 15, 2021

OFAC NOTICE

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").