$250,000.00

STUDENT ACCIDENT INSURANCE

Pays Regardless Of Other Insurance

Choice of **TWO** School Approved Insurance Plans

Plan Administrator
The Allen J. Flood Companies
Two Madison Avenue
Larchmont, NY 10538
1-800-734-9326

Local Agent
The Insurance Market
P.O. Box 637
Laurel, DE 19956
1-800-660-0509

Fairmont Specialty®
part of Crum&Forster group

2016-2017

Underwritten By:
United States Fire Insurance Company

STUDENT ACCIDENT INSURANCE

Who Is Eligible

The policy is available to all enrolled students, faculty and administration of a participating school.

Who Pays The Premium

Coverage is purchased by the parent or guardian of enrolled students or by individual faculty or administrative members interested in enrolling in the program.

Coverage Term

Coverage is effective when the premium is received by the school or administrator or the effective date of the policy, whichever is later.

Coverage expires at 12:01am on the first day of the 2017-2018 school year.

Choice of TWO School Approved Insurance Plans

SCHOOL TIME ACCIDENT COVERAGE

Insurance coverage for the hours and days when school is in session and while attending school sponsored and supervised activities on or off the school premises.

- During school year
- Travel to and from school
- School supervised and sponsored activities
- Religious services

FULL TIME 24 HOUR ACCIDENT COVERAGE

Insurance coverage is in force around the clock. It becomes effective on the earliest of the following: (1) the first day of school if signed enrollment form and premium is received before the seventh school day, or (2) the date the enrollment form and premium are received by the school administrator.

- Any covered activity — Any place — Any time — Anywhere
- 24 hours a day including summer
- Covers weekends and vacation periods
- Insurance protection at home or while away

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for injuries caused by:

(1) intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; commission or attempt to commit a felony or an assault; commission of or active participation in a riot or insurrection; or
(2) declared or undeclared, war or act of war; or
(3) services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay; or
(4) flight in, boarding or alighting from an aircraft except as a fare-paying passenger on a regularly scheduled commercial airline; or
(5) travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle; or
(6) bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding; or
(9) cosmetic surgery, except for reconstructive surgery needed as the result of a covered injury; or
(10) injuries compensable under workers' compensation law or any similar law; or
(11) sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof; except for any bacterial infection resulting from a accidental external cut or wound or accidental ingestion of contaminated food; or
(12) the covered person being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred or 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; or
(13) participation in or practice for non-school sponsored skiing, ice

(7) an accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: the covered person holds a valid learners permit and the covered person is receiving instruction from a driver's education instructor; or

(8) services or treatment rendered by an person who is employed or retained by the policyholder or living in the covered person's household; a parent, sibling, spouse or child of either the covered person or the covered person's spouse, the covered person; or

hockey, lacrosse, soccer or tackle football (applicable to school time coverage only); or

(14) taking part in Senior High School Interscholastic Football and Sports, including travel to and from games and practice, unless specifically provided for in the Policy.

(15) That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited.)

B-CT-24-R-10

FROM _____

_____

_____

City State Zip

RETURN TO:

THE ALLEN J. FLOOD COMPANIES
2 MADISON AVENUE
LARCHMONT, NY 10538

Name of School/District _____

◯ I Accept Coverage ◯ I Decline Coverage

company use only

Date Returned: _____ / _____ / _____

Received By: ❑ School ❑ Administrator

PRIMARY COVERAGE - PAYS REGARDLESS OF ANY OTHER HEALTH CARE PLAN* YOU MAY HAVE...

NOT SURE WHICH PLAN IS RIGHT FOR YOU...

CALL YOUR LOCAL AGENT

THE INSURANCE MARKET
(800) 660-0509

"Health Care Plan" means any contract, policy, or other arrangement, whether individually purchased or incidental to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, blanket, franchise or family or individual policies; subscriber contracts; uninsured agreements or arrangements; coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice and individual-practice plans; medical benefits provided by a governmental plan or coverage or other benefit law, except a state-sponsored Medicaid plan; or a plan or law providing benefits only in excess of any private or non-governmental plan; other valid and collectible medical or health care benefits or services.

Accident Insurance Protection

Providing a Maximum of $250,000.00 Medical Expense

ACCIDENT MEDICAL EXPENSE PRIMARY COVERAGE – PAYS REGARDLESS OF OTHER HEALTH CARE PLAN

Provides for payment of Usual, Reasonable and Customary (URC) Expenses incurred for treatment of an injury caused by a covered accident subject to the maximums stated in the policy. Treatment must be medically necessary and the first expense must be incurred within 90 days following the covered accident. To be payable, other expenses must be incurred within 365 days after the accident. All Benefits will be based on the normal charge, in the absence of insurance, made by the provider of a necessary supply or service, but not more than the prevailing charge in the area for like services by a provider with similar training or experience. Where appropriate, Usual, Reasonable, and Customary Charge will be based on a relative value schedule appropriate to the area and type of service provided.

PLAN 3 COVERED EXPENSES— PER COVERED ACCIDENT

Hospital Services
Daily Room & Board: Average Semi-Private rate, up to $250.00/day
Intensive care, for 7 days.....URC up to $350.00/day
Miscellaneous Hospital Services, while confined
or when surgery performed .....URC up to $2,500.00
Emergency Room (outpatient).....URC up to $200.00

Physician's Services
Surgery (inc. pre-and post operative care)
Computed from the 1974 California Relative Value Schedule-
Number of Units Times Unit Value of $150.00
Visits (when no Surgery paid), except physiotherapy
and similar treatments, per visit up to .....$40.00 - 1st visit
.....$20.00 - After
Anesthetic and Asst. Surgeon, percent of Surgery benefit.....30%
Consultants, second opinions.....URC up to $100.00

Lab & X-Ray, Except Dental X-Rays
X-Ray maximum of $300.00
Laboratory maximum of $150.00

Additional Services
Physiotherapy or similar treatment
-In Hospital.....Inc. in Hosp. Misc.
-Out of Hospital (Maximum 5 visits) $30.00/visit
Prescribed Orthopedic Appliances
Maximum -In Hospital .....Inc. In Hosp. Misc.
-Out of Hospital $250.00
Registered or Licensed Nurse, when prescribed.....URC
Ambulance to initial treatment facility .....URC
Prescribed Drugs and Medicines $100.00

Eyeglasses, Contact lenses, Hearing Aids
Replacement, when broken as the result of a covered
Injury requiring medical treatment .....URC up to $125.00

Dental Services (Includes Dental X-Rays)*
Treatment, repair or replacement - each tooth .....URC up to $250.00

PLAN 4 COVERED EXPENSES— PER COVERED ACCIDENT

Hospital Services
Daily Room & Board: Average Semi-Private rate, up to $75.00/day
Intensive care, for 7 days.....URC up to $125.00/day
Miscellaneous Hospital Services, while confined
or when surgery performed .....URC up to $1,000.00
Emergency Room (outpatient).....URC up to $100.00

Physician's Services
Surgery (inc. pre-and post operative care)
Computed from the 1974 California Relative Value Schedule-
Number of Units Times Unit Value of $100.00
Visits (when no Surgery paid), except physiotherapy
and similar treatments, per visit up to .....$25.00 - 1st visit
.....$10.00 - After
Anesthetic and Asst. Surgeon, percent of Surgery benefit.....20%
Consultants, second opinions.....URC up to $50.00

Lab & X-Ray, Except Dental X-Rays
X-Ray maximum of $150.00
Laboratory maximum of $75.00

Additional Services
Physiotherapy or similar treatment
-In Hospital.....Inc. in Hosp. Misc.
-Out of Hospital (Maximum 5 visits) $20.00/visit
Prescribed Orthopedic Appliances
Maximum -In Hospital .....Inc. In Hosp. Misc.
-Out of Hospital $50.00
Registered or Licensed Nurse, when prescribed.....URC
Ambulance to initial treatment facility. .....URC
Prescribed Drugs and Medicines $25.00

Eyeglasses, Contact lenses, Hearing Aids
Replacement, when broken as the result of a covered
Injury requiring medical treatment .....URC up to $25.00

Dental Services (Includes Dental X-Rays)*
Treatment, repair or replacement - each tooth .....URC up to $100.00

If there is more than one way to treat a dental problem, benefits will be paid for the least expensive procedure provided it meets acceptable dental standards.

ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Provides for payments of benefits in accordance with the following table when Loss results from a covered accident. Loss must result within 365 days of the accident.

Loss of Life $10,000.00

Both hands or both feet
or the sight of both eyes $20,000.00

One hand and one foot.....$20,000.00

One hand and the sight of one eye $20,000.00

One foot and the sight of one eye $20,000.00

One hand or one foot or the sight of one eye.....$10,000.00

"LOSS" means with regard to hands and feet, complete severance through or above the wrist or ankle joint; with reference to the eye, the total permanent loss of sight of the eye. If more than one loss results from any one accident, only one amount, the largest, will be paid. "Severance" means the complete separation and dismemberment of the part from the body.

☐ YES, WE HAVE CHOSEN TO ENROLL FOR ACCIDENT INSURANCE.

COVERAGE CHOSEN FOR 2016-2017 SCHOOL YEAR	PLAN 3 ANNUAL PREMIUM	PLAN 4 ANNUAL PREMIUM
SCHOOL TIME COVERAGE	☐ $ 16.00	☐ $ 8.00
24 HOUR COVERAGE	☐ $ 54.00	☐ $ 30.00

CHECK #_____ TOTAL $_____ DATE SENT_____

CLAIMS PROCEDURE

In case of accident, notify school immediately. Secure claim form from your school, attach bill(s) to completed claim form and mail to the address indicated on the claim form. CLAIMS FOR BENEFITS MUST BE FILED WITHIN 90 DAYS FROM DATE OF LOSS, OR AS SOON AS REASONABLY POSSIBLE.

IMPORTANT NOTICE: This information is a brief description of the important features of this insurance plan. It is not a contract. Terms and conditions of coverage are set forth on policy form GAC26932. This Blanket Policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. **Please keep this material as a reference. An individual I.D. card will not be issued.**

ENROLLMENT FORM FOR STUDENT ACCIDENT INSURANCE 2016/2017

NAME OF SCHOOL: _____ NAME OF DISTRICT: _____ GRADE/DEPT: _____

PERSON TO BE INSURED: _____ DATE OF BIRTH: _____

ADDRESS: _____ STATE: _____ ZIP: _____

PHONE: (_____) CITY: _____

STUDENT ACCIDENT INSURANCE CHOSEN FOR: ☐ STUDENT ☐ FACULTY ☐ ADMINISTRATION

CHECK COVERAGE:	PLAN 3 ANNUAL PREMIUM	PLAN 4 ANNUAL PREMIUM
SCHOOL TIME COVERAGE	☐ $ 16.00	☐ $ 8.00
24 HOUR COVERAGE	☐ $ 54.00	☐ $ 30.00

POLICY NUMBER (COMPANY USE ONLY)

_____

THERE IS NO OBLIGATION TO PURCHASE THIS INSURANCE PLAN.

○ I DO ○ I DO NOT WANT THIS INSURANCE.

SIGNATURE OF PARENT: _____

DATE: _____

AMOUNT ENCLOSED: _____ (DO NOT SEND CASH)

Please include check or money order payable to: United States Fire Insurance Company

DETACH HERE

After SELECTING the School Approved Insurance Plan That's Best for You:

- ☐ Detach and Complete the Enrollment Form
- ☐ Enclose a Check or Money Order Payable to: United States Fire Insurance Company
- ☐ Do Not Send Cash
- ☐ Return to Address on the Envelope

Fairmont Specialty®
part of Crum&Forster group