

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- If you have other insurance, these plans will help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

**24-Hour-A-Day Accident Coverage**  
*(Including Summer Vacation)*

Protects your child for the entire school year and extends throughout the summer - right up to the day school re-opens. Your child's coverage is good WORLDWIDE, 24-HOURS-A-DAY. This includes covered accidents:

- At home
- At school
- While engaged in sports, except those specifically excluded or for which optional coverage is required\*
- At play
- On vacation
- Scouting, camping, etc.
- During covered travel

\*See OPTIONS for available optional sports coverage, if any.

**School-Time Accident Coverage**

Your child is protected while attending regular school sessions. Also covered is travel directly to and from your Residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed.

In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

**Optional Football Only Accident Coverage** begins on the date of premium receipt by GTL, its representatives or school officials, but not prior to the first official date of practice; and continues through the date of the last official game of the current season including playoffs. **Football premium covers football only.**

24-HR-A-DAY	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL), its representatives or school officials (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-hour-a-day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

To file a claim: Report accidents to the school. Forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Complete proof of loss and accumulated bills must be received by Guarantee Trust Life Insurance Company within 90 days.

Blanket Accident Insurance is issued on Form Series GP-2020 by Guarantee Trust Life Insurance Company. This product and its features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. This brochure is a brief description of the coverage. The exact provisions governing the insurance are contained in the Policy issued to the School and certain provisions may be administered to conform to state requirements. For complete details of coverage or questions regarding the cost, please contact the agent administering this program for you.

Administered by: **STUDENT PROTECTIVE AGENCY**  
300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544  
Underwritten and claims paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY**  
1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

**What's Covered? Up to \$25,000.00 as described under Coverage and Benefits for:**

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS FROM ACCIDENTAL BODILY INJURY RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES
- COVERED MEDICAL EXPENSE WHICH BEGINS WITHIN 30 DAYS OF THE ACCIDENT AND IS INCURRED WITHIN 52 WEEKS OF THE ACCIDENT

Benefits are payable up to the dollar amounts shown

<b>COVERAGE and BENEFITS</b>			
<b>BENEFITS PER INJURY</b>		<b>Low Option</b>	<b>High Option</b>
<b>Hospital Room and Board and General Nursing Care</b>	Per day	\$150	\$300
<b>Hospital Miscellaneous Expense</b>		\$1,000	\$2,000
<b>Hospital Emergency Care</b>		\$150	\$300
<b>Doctor's Fees For Surgery</b>	Per Unit Unit Value determined by the Surgical Schedule	\$80	\$160
<b>Anesthesia Services</b>	Percent of Surgical Schedule Allowance	25%	25%
<b>Doctor's Visits Non-Surgical Including Physical Therapy</b>	Per visit	\$25	\$50
	Physical Therapy, per visit Maximum number of visits per Injury	\$25 3 visits	\$50 3 visits
<b>Imaging Procedures</b>	Including X-Rays & Interpretation	\$100	\$200
<b>MRI/CAT scan</b>		\$125	\$250
<b>Ambulance Expense</b>		\$100	\$200

Injury means bodily Injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Insured's coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

**PROTECT YOUR CHILD, PROTECT YOURSELF.**  
Here are your 2017-18 Student Insurance Plans:

**COVERAGE and BENEFITS (continued)**

<b>BENEFITS PER INJURY</b>		<b>Low Option</b>	<b>High Option</b>
<b>Orthopedic Appliances</b>	Furnished by the Hospital	\$100	\$200
<b>Dental Treatment</b>	Treatment For Injury To Sound, Natural Teeth, per tooth Up to a maximum of	\$200 \$600	\$400 \$1,200
<b>Accidental Death and Dismemberment</b>	If Injury causes death or dismemberment within 365 days of the Accident, the plan pays as follows: Only one of these benefits, the largest, will be payable in addition to the benefits shown		Loss of Life \$2,000 Loss of One Hand or One Foot \$1,000 Loss of the Entire Sight of Both Eyes \$1,000 Loss of Both Hands or Feet \$10,000

**EXCLUSIONS - The Policy does not provide benefits for:** 1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are determined to be Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy. 2) Intentionally self-inflicted Injury. 3) Injury received while violating or attempting to violate any duly enacted law. 4) Injury by acts of war, whether declared or not. 5) Injury received while traveling or flying by air, except as a fare-paying passenger on a regularly scheduled commercial airline. 6) Injury covered by Workers' Compensation or the Occupational Disease Law. 7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance. 8) Hernia of any type. 9) Injury sustained fighting or brawling, except in self-defense. 10) Suicide or attempted suicide. 11) Loss resulting from the use of any drug or agent classified as narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor. 12) Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four- wheeled recreational motor/engine driven vehicle or snowmobile or all terrain vehicle (ATV). 13) Injury sustained while participating in or practicing for senior high interscholastic tackle football, including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased. 14) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body. 15) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay. 16) Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs. 17) Dental treatment, except as specifically stated. 18) Services of an assistant surgeon or Doctor when surgery is performed. 19) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore. 20) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

# 2017-18 SCHOOL YEAR ENROLLMENT FORM

ONE TIME ANNUAL PAYMENT		
OPTIONS	LOW OPTION	HIGH OPTION
<b>24-HOUR-A-DAY PLAN</b> STUDENTS GRADES K-6 STUDENTS GRADES 7-12	<input type="checkbox"/> \$83 <input type="checkbox"/> \$96	<input type="checkbox"/> \$166 <input type="checkbox"/> \$192
<b>SCHOOL-TIME PLAN</b> STUDENTS GRADES K-6 STUDENTS GRADES 7-12	<input type="checkbox"/> \$24 <input type="checkbox"/> \$39	<input type="checkbox"/> \$48 <input type="checkbox"/> \$78
<b>OPTIONAL FOOTBALL COVERAGE</b> (GRADES 10-12, INCLUDING GRADE 9 IF PLAYING WITH 10-12) 2017 SEASON ONLY PER PLAYER	<input type="checkbox"/> \$136	<input type="checkbox"/> \$272
<b>TOTAL \$</b> _____ (PLEASE DO NOT SEND CASH)		
<b>MAKE CHECK PAYABLE TO YOUR LOCAL AGENCY</b>		
<b>NO REFUNDS ARE AVAILABLE</b>		

PLEASE PRINT CLEARLY | GUARANTEE TRUST LIFE INSURANCE COMPANY, GLENVIEW, IL

<b>STUDENT'S NAME</b> _____ <small>FIRST NAME                      MIDDLE INITIAL                      LAST NAME</small>		
<b>DATE OF BIRTH</b> _____ <small>MONTH                      DAY                      YEAR</small>	<b>MALE</b> <input type="checkbox"/>	<b>FEMALE</b> <input type="checkbox"/>
<b>SCHOOL DISTRICT</b> _____		<b>SCHOOL</b> _____
<b>GRADE</b> _____ <b>STUDENT'S ADDRESS</b> _____		
<b>CITY</b> _____		<b>STATE</b> _____ <b>ZIP</b> _____
<b>TELEPHONE #</b> _____		<b>DATE OF APPLICATION</b> _____
<b>PARENT OR GUARDIAN'S EMAIL ADDRESS</b> _____		
<b>NAME OF PARENT OR GUARDIAN (PLEASE PRINT)</b> _____		
<b>SIGNATURE OF PARENT OR GUARDIAN</b> _____		

GA-15-KEF

## PLEASE REMEMBER TO:



COMPLETE THE ENROLLMENT FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.



MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE ENROLLMENT FORM WITH YOUR CHECK OR MONEY ORDER TO:



### STUDENT PROTECTIVE AGENCY

300 Coshocton Avenue  
Mount Vernon, OH 43050



PLEASE NOTE: YOUR CANCELED CHECK IS YOUR RECEIPT. IF CANCELED CHECK IS NOT RECEIVED WITHIN 60 DAYS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR.

# **NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM**

## **INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM**

- The claim form must be completed and signed by the Organization **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Group or Association name on the claim form. Also, the "Authorization To Permit Use and Disclosure of Health Information" must be signed.
- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your policy for the "Initial Treatment Period".
- **PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED WITHIN 90 DAYS OF THE ACCIDENT. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED WITHIN 90 DAYS OF TREATMENT.**
- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
  - 1) **The date(s) of treatment,**
  - 2) **The type(s) of service,**
  - 3) **The diagnosis,**
  - 4) **The medical provider's name and address**
  - 5) **The individual charge for each expense.**
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement. **Please note:** This is not necessary if you have purchased a "Primary" plan through GTL that pays regardless of other insurance payments.
- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
**P.O. Box 1148**  
**Glenview, Illinois 60025**

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

### **IMPORTANT:**

**Please take note that your claim will result in a processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.**

*If you have any questions, please contact our Customer Service Department at (800) 622-1993.*

NAME OF SCHOOL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY NO. \_\_\_\_\_

IMPORTANT! THIS INFORMATION  
MUST BE GIVEN OR CLAIM WILL  
BE RETURNED

GUARANTEE TRUST LIFE INS. CO.  
P.O. Box 1148  
Glenview, IL 60025  
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: \_\_\_\_\_ Hosp.: \_\_\_\_\_ Other: \_\_\_\_\_  
Addr: \_\_\_\_\_ Addr: \_\_\_\_\_ Addr: \_\_\_\_\_  
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_  
Claimant - if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. Claimant's FULL NAME \_\_\_\_\_ Alternate Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_
2. Claimant's Address: Street or RFD \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Date of Accident \_\_\_\_\_ 20\_\_\_\_ Hour \_\_\_\_\_ AM  PM
4. Description of Accident: (A) How and where did in occur? \_\_\_\_\_  
(if more space needed, attach separate sheet)  
(B) Nature of Injury \_\_\_\_\_
5. Description of Activity (What was the Claimant doing at time of injury?) \_\_\_\_\_  
If Athletics, name sport \_\_\_\_\_ Intramural  Interscholastic  Other
6. (A) On date of accident what time did school start for this student? \_\_\_\_\_ AM  PM   
(B) What time was student dismissed from school? \_\_\_\_\_ AM  PM
7. Has a previous claim been filed for this accident? Yes  No
8. (A) Name of School Authority supervising Activity \_\_\_\_\_  
(B) Was Supervisor a witness? Yes  No   
(C) If not, when was accident reported to School Authority? \_\_\_\_\_

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary  Jr. High  High  Other

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report \_\_\_\_\_ Signature of Official \_\_\_\_\_ Title \_\_\_\_\_

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY?  NO  YES  
IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:

Insurance Company Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Policy # \_\_\_\_\_

10. Parents Name: Father \_\_\_\_\_ Mother \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Claimant, or Parent if Claimant is a minor)

**Note: Your State Insurance Department requires us to notify you that:** 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.

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
1275 Milwaukee Avenue, Glenview, Illinois 60025  
1-800-622-1993

**HIPAA AUTHORIZATION**  
To Permit Use and Disclosure of Health Information

**This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.**

Policy/Certificate # \_\_\_\_\_

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

\_\_\_\_\_  
(Print Please) Name of Patient Date of Birth

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
(Please Print) Name of Authorized Representative, or Next of Kin

\_\_\_\_\_  
Relationship of Authorized Representative or Next of Kin to Patient

\_\_\_\_\_  
Signature of Authorized Representative or Next of Kin Date