

Dear Parents:

Our school district has made arrangements with Student Protective Agency to provide student accident and health insurance for those wishing to purchase coverage this year. Please note the coverage shown on the application. Covered losses less than \$250 are paid without regard to other insurance. Please note the option to purchase 24 hour accident and sickness coverage is available to be purchased within 75 days of the school year or moving into the district of loss of other coverage.

Senior High football coverage requires an additional premium. All other school supervised sports are covered under the plan. On claims over \$250 this is an excess coverage policy for which benefits are payable only for that part of the loss not covered by other collectible insurance. If a person has no other insurance, the Company will pay the covered medical expenses incurred within one year, up to the specified limits of the policy.

Please note that the student applications will be available on our website. Complete the application and check the boxes for coverage desired. Sign where life insurance is shown, if desired. Tear off and keep the rest of the application, as it shows not only the coverage but the exclusions and limitations of the policy.

Mail the applications directly to Student Protective Agency, 300 Coshocton Avenue, Mount Vernon, OH 43050 along with a money order of check payable to Student Protective or go to [www.studentprotective.com](http://www.studentprotective.com). The school will be notified as to who takes out coverage. You can call Student Protective at 1-800-278-2544 for more information.

In case of an accident the student or parent should immediately go to the building principal who will sign and provide the claim form if only school time coverage is taken out. 24 hour coverage needs no signature. The policy number shall be provided by the school for the claim or you can call 1-800-278-2544. You may give that policy number to the doctor or hospital but the bills should be sent to the parent or guardian who attach them to the claim form. Once completed, mail to the claims office at Guarantee Trust Life Insurance, PO Box 1148, Glenview, IL 60025. If you have any further questions regarding a claim, please call 1-800-622-1993. It is the responsibility of the parent or guardian to file the claim.

# 2023-24 OHIO STUDENT ACCIDENT INSURANCE PROGRAM

## Multi-Benefit Protection

*Plan Administered by:*

**Student  
Protective  
Agency**

300 Coshocton Ave.  
Mount Vernon, OH 43050  
1-800-278-2544



### ***ACCIDENT INSURANCE PROTECTION HELPING PROVIDE:***

**For the Student** - Sound coverage with a selection of plan options

**For the Parent** - Additional financial security to help in times of increasing medical costs

**For You** - The fulfillment of an administrative service and responsibility

*Underwritten & Claims Administered by:*

**GTL** | **GUARANTEE  
TRUST  
LIFE**

Guarantee Trust Life Insurance Company (GTL)  
1275 Milwaukee Ave., Glenview, IL 60025  
1-800-622-1993  
[www.gtlic.com](http://www.gtlic.com)



# ACCIDENT INSURANCE PLANS

for all students and athletes

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**SCHOOL-TIME STUDENT ACCIDENT COVERAGE:** Helps protect your students the entire school year, during regular school sessions, as well as participating in other school-sponsored activities requiring the attendance of the student. Also provides protection for your students while traveling directly to or from the student's Residence and school to attend or participate in school activities. The expiration date of coverage shall be the close of the regular nine month school term, except while the Insured is attending academic classroom sessions exclusively sponsored and solely supervised by the school during the summer.

**24-HOUR-A-DAY ACCIDENT COVERAGE:** Provides protection for your students 24-hours-a-day, year-round and continues until the end of the Policy Year. The student is protected AT HOME, AT SCHOOL, AT CAMP, ON VACATION. . . ANYWHERE ACCIDENTS CAN HAPPEN.

**SPORTS ACCIDENT COVERAGE:** Interscholastic sports (including practice) are covered by the School-Time and 24-Hour-A-Day Accident Coverage. Travel is also covered when going directly and uninterruptedly to and from practice or competition when traveling as a group in a Designated Vehicle. High school tackle football for grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) is only covered by the optional Football Only Accident Coverage, which requires an additional premium.

**FOOTBALL ONLY ACCIDENT COVERAGE:** Players in Grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) are covered for accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is also covered when going directly and uninterruptedly to and from such practice or competition when traveling as a group in a Designated Vehicle.

**EFFECTIVE COVERAGE DATES:** Coverage will be effective on the date of premium receipt by GTL, its representatives or school officials, or the official first day of school, whichever is later.

For interscholastic sports, coverage can pre-date the official first day of school for students who are participating in pre-school practice sessions, competition or covered travel sanctioned by the Ohio High School Athletic Association. In such cases coverage will be effective as of the date of premium receipt but only while participating in actual practice sessions, competitions or covered travel. Other aspects of coverage will not commence until the official first day of school.

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 no earlier than August 1st as sanctioned by the Ohio High School Athletic Association and continues through the date of the last official game of the 2023 season, including playoffs. Other aspects of coverage will not commence until the official first day of school.

**EXCESS PROVISION:** All Covered Charges will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance covers the Insured person.

## 2023-24 POLICY BENEFITS AND PREMIUMS

**All Maximum amounts are per Injury except as specifically stated.**

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 Covered Person'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.

COVERAGE AND BENEFITS	LOW OPTION	HIGH OPTION
Maximum Benefit Amount Per Injury	\$25,000.00	\$25,000.00
Deductible	\$0.00	\$0.00
Hospital Room and Board and general nursing care limited to a maximum of	\$150.00/day	\$300.00/day
Hospital Miscellaneous Expense limited to a maximum of	\$1,000.00	\$2,000.00
Hospital Emergency Care limited to a maximum of	\$150.00	\$300.00
Orthopedic Appliances furnished by the Hospital limited to a maximum of	\$100.00	\$200.00
Doctor's fees for surgery, in accordance with the Surgical Schedule using	\$80.00 per unit value	\$160.00 per unit value
Anesthesia Services, limited to	25% of the Surgical Schedule allowance	25% of the Surgical Schedule allowance
Non-Surgical Doctors' Visits, including Physical Therapy Physical Therapy is limited to a maximum benefit of 3 visits.	\$25.00	\$50.00
Dental Treatment, per tooth (for Injury to Sound, Natural Teeth) limited to Up to a maximum of	\$200.00 \$600.00	\$400.00 \$1,200.00
Imaging procedures, including X-rays and interpretation, limited to a maximum of amount of	\$100.00	\$200.00
MRI/CAT Scan, up to a maximum benefit of	\$125.00	\$250.00
Ambulance Expense, limited to a maximum of	\$100.00	\$200.00
Loss of Life	\$2,000.00	\$2,000.00
Loss of One Hand or One Foot or Entire Sight of Both Eyes	\$1,000.00	\$1,000.00
Loss of both Hands or Feet	\$10,000.00	\$10,000.00
PREMIUMS (ONE-TIME PAYMENT)	LOW OPTION	HIGH OPTION
<b>SCHOOL-TIME ACCIDENT COVERAGE</b>		
Students — Grades K - 6	\$23.00	\$46.00
Grades 7 - 12	\$37.00	\$74.00
<b>24-HOUR-A-DAY ACCIDENT COVERAGE</b>		
Students — Grades K - 6	\$79.00	\$158.00
Grades 7 - 12	\$91.00	\$182.00
<b>OPTIONAL FOOTBALL ONLY ACCIDENT COVERAGE</b>		
Per Player — Grades 10 - 12 (including grade 9 if playing or practicing with grades 10 through 12)	\$129.00	\$258.00



## EXCLUSIONS

**THE POLICY DOES NOT COVER:** (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are 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 sustained 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 Worker's 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 an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four-wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) 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; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) 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; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

## IMPORTANT INFORMATION

1. Treatment must begin within thirty (30) days of Accident.
2. Expense must be incurred within fifty-two (52) weeks of Accident.
3. Written proof of loss must be furnished within ninety (90) days of Accident.
4. No refunds are available.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help 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 can 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	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.

**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.**

**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.

## 24-HOUR-A-DAY ACCIDENT COVERAGE

### 24-Hour-A-Day Protection for each Covered Accident

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

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

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

## SCHOOL-TIME ACCIDENT COVERAGE

Helps protect your child while attending regular school sessions. Includes coverage for 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.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

## 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

## COVERAGE AND BENEFITS

BENEFITS ARE PAYABLE UP TO THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		LOW OPTION	HIGH OPTION	BENEFITS PER INJURY		LOW OPTION	HIGH OPTION
HOSPITAL ROOM AND BOARD AND GENERAL NURSING CARE	Per day	\$150	\$300	IMAGING PROCEDURES	Including X-rays and interpretation	\$100	\$200
HOSPITAL MISCELLANEOUS EXPENSE		\$1,000	\$2,000	MRI/CAT Scan		\$125	\$250
HOSPITAL EMERGENCY CARE		\$150	\$300	ORTHOPEDIC APPLIANCES	Furnished by the Hospital	\$100	\$200
DOCTOR'S FEES FOR SURGERY	Per Unit Unit Value determined by the Surgical Schedule	\$80	\$160	DENTAL TREATMENT	For Injury to Sound, Natural Teeth, per tooth Up to a maximum of	\$200 \$600	\$400 \$1,200
ANESTHESIA SERVICES	Percent of Surgical Schedule Allowance	25%	25%	ACCIDENTAL DEATH AND DISMEMBERMENT  Only one of these benefits, the largest, will be payable in addition to other benefits shown	Caused by an Injury and occurring within 365 days of the covered Accident	<b>ACCIDENTAL DEATH</b> \$2,000  <b>DISMEMBERMENT</b> 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	
AMBULANCE EXPENSE		\$100	\$200				
DOCTORS' VISITS Non-surgical Including Physical Therapy	Per visit	\$25	\$50				
	Physical Therapy, per visit Maximum number of visits per Injury	\$25 3	\$50 3				

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.

### EXCLUSIONS

THE POLICY DOES NOT COVER: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are 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 sustained 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 Worker's 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 an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four- wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained while participating in or practicing for senior high inter-scholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) 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; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

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 (GTL)**, 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

# 2023-2024 SCHOOL YEAR ENROLLMENT FORM



PLEASE PRINT CLEARLY

ONE TIME ANNUAL PAYMENT		
OPTIONS	LOW OPTION	HIGH OPTION
<b>24-HOUR-A-DAY PLAN</b>		
STUDENTS GRADES K-6	<input type="checkbox"/> \$79	<input type="checkbox"/> \$158
STUDENTS GRADES 7-12	<input type="checkbox"/> \$91	<input type="checkbox"/> \$182
<b>SCHOOL-TIME PLAN</b>		
STUDENTS GRADES K-6	<input type="checkbox"/> \$23	<input type="checkbox"/> \$46
STUDENTS GRADES 7-12	<input type="checkbox"/> \$37	<input type="checkbox"/> \$74
<b>OPTIONAL FOOTBALL COVERAGE</b> (GRADES 10-12, INCLUDING GRADE 9 IF PLAYING WITH 10-12) 2023 SEASON ONLY PER PLAYER		
	<input type="checkbox"/> \$129	<input type="checkbox"/> \$258
<b>TOTAL \$</b> _____ (PLEASE DO NOT SEND CASH)		
<b>MAKE CHECK PAYABLE TO YOUR LOCAL AGENCY</b>		
<b>NO REFUNDS ARE AVAILABLE</b>		

<b>STUDENT'S NAME</b>		
FIRST NAME _____	MIDDLE INITIAL _____	LAST NAME _____
<b>DATE OF BIRTH</b> _____		<b>MALE</b> <input type="checkbox"/> <b>FEMALE</b> <input type="checkbox"/>
MONTH _____	DAY _____	YEAR _____
<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 ENROLLMENT</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.



- ¡Los accidentes son comunes! Cuando le suceden a su hijo, alguien debe pagar esos costos.
- Aquí le presentamos planes de seguros contra accidentes para cubrir a su hijo las 24 horas del día (Plan de 24 horas) o en la escuela (Plan de Tiempo Escolar).
- Estos planes ofrecen beneficios para ayudar a cubrir el costo de los gastos médicos y hospitalarios.
- Si tiene otro Seguro, estos planes pueden ayudar a compensar los deducibles y coaseguro de dichos planes.
- Si no tiene otro seguro, estos planes proporcionarán cobertura básica.
- Cualquier beneficio pagable por esta póliza como resultado de un servicio médico, quirúrgico, dental, hospitalario o de enfermería será pagado directamente al hospital o a la persona que proporcione dichos servicios, a menos que se proporcione prueba del pago completo.

24-Horas	Tiempo Escolar	DETALLES IMPORTANTES SOBRE LA PROTECCIÓN
✓	✓	Entra en vigor en la fecha en que Guarantee Trust Life Insurance Company (GTL) sus representantes o funcionarios escolares reciben el pago de la prima (pero no antes del primer día de clases). Los estudiantes que participen en prácticas preescolares o practiquen deportes interescolares autorizados por la Asociación Atlética de Escuelas Secundarias de Ohio estarán cubiertos a partir de la misma fecha del pago de la prima, pero solo mientras participen en sesiones de práctica o juego. Otros aspectos de la cobertura no entrarán en vigor hasta el primer día de clases regulares.
✓	✓	Proporciona cobertura durante las horas en las cuales la escuela está en actividades regulares.
✓		Proporciona cobertura las 24 horas del día.
✓	✓	Ofrece cobertura durante el tiempo necesario para el viaje entre la casa del asegurado y el comienzo o final de clases regulares.
✓	✓	Brinda cobertura mientras participa (o asiste) a actividades organizadas, patrocinadas y supervisadas por la escuela. También se proporciona cobertura para viajar directamente hacia y desde tales actividades en un Vehículo Designado provisto por la escuela.
	✓	La cobertura expira al terminar el ciclo escolar regular. (La cobertura se extenderá mientras se asista a clases académicas para obtener créditos en el verano, cuando las actividades escolares son patrocinadas y supervisadas exclusiva y únicamente por la escuela, no se proporcionará cobertura para el transporte de y hacia las clases.)
✓		La cobertura continúa sin interrupción todo el verano, hasta que la escuela inicie el siguiente ciclo escolar.

La cobertura opcional de fútbol comienza en la fecha en que GTL, sus representantes o los oficiales de la escuela reciban la prima, pero no antes de la primera fecha oficial de entrenamiento, y continúa hasta la fecha del último partido oficial de la temporada actual, incluyendo las eliminatorias.  
**La prima de fútbol cubre solo fútbol.**

Para presentar un reclamo: reporte los accidentes a la escuela. Los formularios se proporcionarán a través de la oficina del director (durante las vacaciones, comuníquese con los administradores del plan). La prueba completa de la pérdida y las facturas acumuladas debe ser recibida por Guarantee Trust Life Insurance Company dentro de los 90 días posteriores al accidente.

## COBERTURA DE ACCIDENTES LAS 24 HORAS DEL DÍA

### ¡Protección las 24 horas para cada accidente cubierto!

Proteja a su hijo durante todo el año escolar y se extiende durante el verano - hasta que la escuela inicie nuevamente.

Su hijo estará cubierto EN TODO EL MUNDO, LAS 24 HORAS DEL DÍA.

Esto incluye accidentes cubiertos: ☞ En el hogar ☞ Al jugar ☞ En la escuela

☞ Durante las vacaciones ☞ Al acampar, explorar, etc. ☞ Durante viajes cubiertos

☞ Mientras participe en deportes, excepto aquellos que estén excluidos específicamente o para los cuales se requiere cobertura opcional\*

\*Vea las OPCIONES para descubrir cualquier cobertura opcional para deportes.

## COBERTURA DE ACCIDENTES DURANTE EL TIEMPO ESCOLAR

Ayuda a proteger a su hijo mientras asiste a clases regulares. Incluye cobertura para los viajes directos hacia y desde su residencia para asistir a clases regulares, durante el tiempo de viaje requerido, pero durante no más de una hora antes o después de las clases regulares. El tiempo de viaje en el autobús escolar se extiende por cualquier tiempo adicional necesario. Además, se ofrece cobertura mientras se participa en (o se asiste) a actividades cubiertas organizadas, patrocinadas y supervisadas exclusivamente por la escuela y los empleados de la escuela, incluido el viaje directo hacia y desde la actividad en un Vehículo designado proporcionado por la escuela y supervisado únicamente por los empleados de la escuela. Es posible que se requiera cobertura opcional para los deportes interescolares. Consulte OPCIONES para conocer la cobertura deportiva opcional disponible, si corresponde.

Los productos de seguro de Blanket Accident se emiten en Form Series GP-2030, GP-2020 o GP-1200 por Guarantee Trust Life Insurance Company, Glenview, IL. Estos productos y sus características están sujetos a la disponibilidad del estado y pueden variar según el estado. Ciertas exclusiones y limitaciones pueden aplicar. Las disposiciones exactas que rigen el seguro están contenidas en la Política emitida al Titular de la Póliza y ciertas disposiciones pueden administrarse para cumplir con los requisitos del estado. La Política controlará en caso de conflicto entre la Política y este folleto. Para obtener detalles completos de la cobertura, comuníquese con el agente que administra el programa.

## ¿Qué cubren? Hasta un máximo de \$25,000 de acuerdo a la descripción de Cobertura y Beneficios:

- Accidentes que ocurran durante la vigencia de la cobertura.
- Pérdida debido a lesiones accidentales que resulten directa e independientemente de todas las otras causas.
- Gastos médicos cubiertos que comienzan dentro de los 30 días posteriores al accidente e incurridos dentro de las 52 semanas posteriores al accidente.

## COBERTURA Y BENEFICIOS

Los beneficios se pagan *hasta el* monto en dólares especificado a continuación

BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta	BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta
ALOJAMIENTO Y COMIDA EN HOSPITAL Y CUIDADOS GENERALES DE ENFERMERÍA	Por día	\$150	\$300	PROCEDIMIENTOS DE IMAGENOLOGÍA	Incluye radiografías e interpretación	\$100	\$200
				EXPLORACIÓN POR MRI/TAC		\$125	\$250
GASTOS VARIOS DE HOSPITAL		\$1,000	\$2,000	APARATOS ORTOPÉDICOS	Provistos por el hospital	\$100	\$200
ATENCIÓN DE EMERGENCIA HOSPITALARIA		\$150	\$300	TRATAMIENTO DENTAL	Para Lesiones en dientes naturales sanos, por diente	\$200	\$400
HONORARIOS MÉDICOS POR CIRUGÍA	Por unidad	\$80	\$160		Hasta un máximo de	\$600	\$1,200
	Valor unitario determinado por el Cronograma Quirúrgico						
SERVICIOS DE ANESTESIA	Porcentaje de Asignación de Cronograma Quirúrgico	25%	25%	MUERTE ACCIDENTAL Y DESMEMBRAMIENTO	Causado por una lesión y ocurrido dentro de los 365 días posteriores al accidente cubierto	\$2,000	
GASTOS DE AMBULANCIA		\$100	\$200	Solo uno de estos beneficios, el más grande, será pagadero además de otros beneficios que se mencionan	MUERTE ACCIDENTAL		
CONSULTAS MÉDICAS No quirúrgicas Incluye terapia física	Por consulta	\$25	\$50		Pérdida de una mano o un pie	\$1,000	
	Terapia física por consulta	\$25	\$50		Pérdida de la vista completa de ambos ojos	\$1,000	
	Número máximo de consultas por lesión	3	3		Pérdida de ambas manos o pies	\$10,000	

Una Lesión es toda Lesión corporal originada en un Accidente que resulte directa e independientemente de una enfermedad, dolencia corporal o cualquier otra causa; que única, directa e independientemente de todas las demás causas, resulte en gastos médicos; que ocurra después de la fecha de entrada en vigor de la cobertura del Asegurado por la Póliza; y que ocurra mientras la Póliza esté en vigor. Todas las lesiones sufridas en cualquier Accidente, entre ellas todas las condiciones relacionadas y los síntomas recurrentes de estas lesiones, son consideradas una sola Lesión.

**EXCLUSIONS - LA PÓLIZA NO CUBRE:** (1) tratamientos, servicios o suministros que no sean Médicamente necesarios; no recetados por un Médico como necesarios para tratar una Lesión; de naturaleza experimental/de investigación; recibidos sin cargo ni obligación legal de pago; recibidos de personas empleadas o contratados por el Titular de la Póliza o cualquier Miembro de la Familia, salvo que se especifique lo contrario; o no catalogados específicamente como Cargos Cubiertos en la Póliza; (2) lesiones autoinfligidas intencionalmente; (3) lesiones sufridas al violar o intentar violar cualquier ley debidamente promulgada; (4) lesiones por actos de guerra, declarada o no; (5) lesiones recibidas durante un viaje o vuelo, excepto en el caso en el que se viaje como pasajero que paga una tarifa en una aerolínea comercial regular; (6) lesiones cubiertas por la Ley de Compensación al Trabajador o la Ley de Enfermedades Ocupacionales; (7) tratamientos de enfermedades, dolencias o infecciones, excepto infecciones que resulten de una Lesión accidental o infecciones que resulten de la ingestión accidental, involuntaria o no intencional de una sustancia contaminada; (8) hernias, de cualquier tipo; (9) lesiones sufridas en peleas o reyertas, excepto en defensa propia; (10) suicidio o intento de suicidio; (11) cualquier sanción impuesta por otro seguro o plan válido y cobrable por no seguir los procedimientos del plan; (12) pérdida resultante del uso de cualquier droga o agente clasificado como narcótico, psicofármaco, psicodélico, alucinógeno o que tenga una clasificación o efecto similar, a menos que sea recetado por un Médico; (13) lesiones sufridas al operar, viajar en, subirse o bajarse de cualquier vehículo recreativo de dos, tres o cuatro ruedas con motor, motonieve o vehículo todo terreno (ATV, por sus siglas en inglés); (14) lesiones sufridas mientras se participa en o practicaba fútbol americano interescolar de escuela preparatoria, incluido el grado 9 si jugaba en el grado 10 o superior, incluido el viaje, a menos que se haya comprado una cobertura opcional; (15) cirugías cosméticas o plásticas, excepto cirugías reconstructivas en una parte lesionada del cuerpo; (16) tratamientos en cualquier Administración de Veteranos u Hospital federal, excepto si existe una obligación legal de pago; (17) pérdida resultante de estar legalmente intoxicado o bajo la influencia del alcohol según lo definido por las leyes del estado en el que ocurre la Lesión; (18) tratamientos odontológicos, salvo que se indique específicamente; (19) servicios de un cirujano asistente o Doctor cuando se realiza una cirugía; (20) anteojos, lentes de contacto, exámenes oculares de rutina o recetas para los mismos; (21) medicamentos recetados, muletas, aparatos ortopédicos, miembros artificiales, etc., salvo que se indique específicamente.

Administrado por: **STUDENT PROTECTIVE AGENCY**, 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

Pagadas por: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**, 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

# FORMULARIO DE INSCRIPCIÓN PARA EL AÑO ESCOLAR 2023-24

**GTL** | GUARANTEE TRUST LIFE

POR FAVOR ESCRIBIR CLARAMENTE:

SOLO UN PAGO POR AÑO		
OPCIONES	Opción Baja	Opción Alta
PLAN DE 24 HORAS AL DÍA ESTUDIANTES DE GRADOS K-6	<input type="checkbox"/> \$79	<input type="checkbox"/> \$158
ESTUDIANTES DE GRADOS 7-12	<input type="checkbox"/> \$91	<input type="checkbox"/> \$182
PLAN DE TIEMPO ESCOLAR ESTUDIANTES DE GRADOS K-6	<input type="checkbox"/> \$23	<input type="checkbox"/> \$46
ESTUDIANTES DE GRADOS 7-12	<input type="checkbox"/> \$37	<input type="checkbox"/> \$74
COBERTURA OPCIONAL DE FÚTBOL (GRADOS 10-12, INCLUYENDO GRADO 9 SI SE JUEGA EN 10-12) TEMPORADA 2023 SOLO POR JUGADOR	<input type="checkbox"/> \$129	<input type="checkbox"/> \$258
<b>TOTAL \$</b> _____ Por favor no envíe efectivo		

EXTIENDA EL CHEQUE A FAVOR DE SU AGENCIA LOCAL

NO HAY REEMBOLSOS DISPONIBLES

**NOMBRE DEL ESTUDIANTE** \_\_\_\_\_  
PRIMER NOMBRE \_\_\_\_\_ INICIAL 2o. NOMBRE \_\_\_\_\_ APELLIDO \_\_\_\_\_

**FECHA DE NACIMIENTO** \_\_\_\_\_ **MASCULINO** ☐ **FEMENINO** ☐  
MES \_\_\_\_\_ DÍA \_\_\_\_\_ AÑO \_\_\_\_\_

**DISTRITO ESCOLAR** \_\_\_\_\_ **ESCUELA** \_\_\_\_\_

**GRADO** \_\_\_\_\_ **DIRECCIÓN DEL ESTUDIANTE** \_\_\_\_\_

**CIUDAD** \_\_\_\_\_ **ESTADO** \_\_\_\_\_ **CÓDIGO POSTAL** \_\_\_\_\_

**TELÉFONO #** \_\_\_\_\_ **FECHA DE INSCRIPCIÓN** \_\_\_\_\_

**CORREO ELECTRONICO DEL PADRE O TUTOR** \_\_\_\_\_

**Nombre Del Padre O Tutor (En Letra De Molde)** \_\_\_\_\_

**FIRMA DEL PADRE O TUTOR** \_\_\_\_\_

## POR FAVOR RECUERDE:



COMPLETAR EL FORMULARIO DE INSCRIPCIÓN Y MARCAR EL PLAN Y LAS OPCIONES QUE DESEA.



EMITIR SU CHEQUE O GIRO POSTAL (POR FAVOR NO ENVÍE EFECTIVO) POR EL TOTAL A PAGAR DE ACUERDO A LO INDICADO.

**Envíe su formulario de inscripción con su cheque o el giro postal a:**



**STUDENT PROTECTIVE AGENCY**  
300 Coshocton Avenue  
Mount Vernon, OH 43050



TENGA EN CUENTA: SU CHEQUE CANCELADO ES SU RECIBO. SI EL CHEQUE CANCELADO NO SE RECIBE DENTRO DE LOS 60 DÍAS, COMUNÍQUESE CON EL ADMINISTRADOR DE SU PLAN.

# **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 it's 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



# SPECIAL EVENTS

## ACCIDENT INSURANCE

*Including:*

Adult/Bible School, Theater, Dance, Picnics, Marathons, Boating,  
White Water Rafting, Hunting, Air Travel, Land Travel, and many more

*Underwritten and Claims Paid by:*

Guarantee Trust Life Insurance Company (GTL)  
1275 Milwaukee Avenue, Glenview, IL 60025  
1-800-622-1993  
[www.gtlic.com](http://www.gtlic.com)

*Plan Administered by:*

**Student  
Protective  
Agency**

300 Coshocton Ave. | Mount Vernon, OH 43050  
1-800-278-2544



**WHAT IS IT?** Guarantee Trust Life Insurance Company (GTL) offers Accident Insurance for the specific needs of individuals and groups participating in a variety of Special Events. Since all eligible persons are required to be protected by the plan, no individual names are necessary. The group, along with each individual is protected because all of the eligible persons are covered. There are no voluntary enrollment plans available.

**WHAT IS COVERED?** Each of the activities noted in the enrollment form which is sponsored and directly supervised by the Policyholder; provided the dates of such activities and anticipated number of eligible persons are shown on the premium report.

**WHO IS COVERED?** Eligible persons are either the participants only *or* participants and staff.

**WHAT ARE THE BENEFITS?** ACCIDENT MEDICAL EXPENSE - For expense incurred due to a covered Accident. The Plan will pay, up to the Maximum Benefit Amount indicated on the enrollment form, for Medically Necessary, Reasonable and Customary charges for: 1) Hospital room and board and general nursing care. 2) Intensive care. 3) Urgent care center expense. 4) Hospital miscellaneous expense during Hospital confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies. 5) Anesthesia services. 6) Hospital Emergency care. 7) Doctor's fees for surgery. 8) Doctor's visits, including Physical Therapy. 9) X-ray and laboratory services. 10) Ambulance expense. 11) Dental treatment for Injury to Sound, Natural Teeth. 12) Registered nurse expense. 13) Prescription Drugs. 14) Outpatient services. 15) Casts, non-surgical.

Treatment of Injury must begin within 30 days of the covered Accident and medical expense must be incurred within 52 weeks from the date of covered Accident.

ACCIDENTAL DEATH & DISMEMBERMENT - GTL will pay up to the maximum benefit amount as shown on the enrollment form. If more than one such loss is sustained as the result of one covered Accident, GTL will pay only one amount, the largest to which the Insured person is entitled.

**HOW ARE MEDICAL EXPENSE BENEFITS DETERMINED?** Except where prohibited by law, all Covered Charges will be considered for payment on an excess basis if Other Valid and Collectible Insurance or Plan covers the Insured person.

**HOW DO YOU APPLY FOR COVERAGE?** Complete the enrollment form (front and back). Send the completed enrollment form along with your check made payable to Guarantee Trust Life Insurance Company to the Plan Administrator prior to the requested effective date. After the completed enrollment form and premium are received by the Plan Administrator, you will receive your Policy, claim forms and instructions.

**WHAT ARE THE EXCLUSIONS OF THE POLICY?** Except where prohibited by law, benefits are not provided 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 by the Company; are received without charge or legal obligation to pay; are received from any persons retained or employed by the Policyholder or any Family Member; are not specifically listed as Covered Charges in the Policy. 2) Eyeglasses, contact lenses, routine eye exams or prescriptions. 3) Suicide or attempted suicide while sane or insane. 4) Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law. Injury by acts of war, whether declared or not. 5) Dental treatment, except as specifically stated. 6) Injury covered by Worker's Compensation or the Occupational Disease Law. 7) Hernia of any kind. 8) Injury contributed to by the use of alcohol or drugs not prescribed by a Doctor. 9) Injury incurred as the result of aggravation or reinjury of a Pre-existing Condition. 10) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline. 11) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance. 12) Injury sustained while participating in or practicing for interscholastic athletics, including travel.

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Group Blanket Accident insurance is issued on Form Series GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. 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 Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

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**GUARANTEE TRUST LIFE INSURANCE COMPANY, Glenview, Illinois**

Enrollment for: Accident Insurance

Please print or type - Complete both sides

Name of Policyholder \_\_\_\_\_

Policy Number (company use only) \_\_\_\_\_

Mailing Address \_\_\_\_\_

Policy Term: Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

**Covered Activities: The Special Event activity(ies) noted below which are sponsored and directly supervised by the Policyholder.**

DEDUCTIBLE PER INJURY - \$0	Maximum Benefit Amounts (select ONLY one option) '	
	OPTIONS	
BENEFITS	STANDARD <input type="checkbox"/>	DELUXE <input type="checkbox"/>
Accidental Death	\$5,000	\$12,500
Accidental Dismemberment, <i>Up To</i>	\$10,000	\$25,000
Accident Medical Expense	\$25,000	\$25,000
<b>Premium Rates Per Eligible Person, Per Day</b>		
EVENT TYPES	STANDARD	DELUXE
1. Adult/Bible School	\$0.11	\$0.13
2. Theater, Dance, Parade, Picnic, Reunion	\$0.15	\$0.17
3. Boating, Bowling, Fishing, Hunting	\$0.30	\$0.32
4. Martial Arts, Whitewater Rafting	\$1.90	\$2.00
5. Air Travel, Backpacking, Bicycle Tour	\$0.27	\$0.33
6. Other Land Trip or Tours	\$0.16	\$0.17
7. Spectators at above events	N/A	\$0.20
<b>NO REFUNDS ARE AVAILABLE</b>		

**Policy to Cover all Eligible Persons, including:** ☐ Participants Only ☐ Participants and Staff

The Policy will become effective on the date requested if the appropriate premium has been received prior to the requested effective date. It is agreed that the premium will be paid entirely by the Policyholder with no contribution made by the eligible persons toward the cost of the insurance.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Agent Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

## PREMIUM REPORT

Must be completed for enrollment to be processed - Complete both sides

DATES OF ACTIVITIES	NUMBERS OF ELIGIBLE PERSONS ANTICIPATED TO BE INSURED		Total	DAILY PREMIUM RATE	PREMIUM PER DAY	NUMBER OF DAYS	PREMIUM DUE
	Participants	Staff					
_____ THRU _____	_____ + _____	= _____	X _____	= \$ _____	X _____	= \$ _____	
_____ THRU _____	_____ + _____	= _____	X _____	= \$ _____	X _____	= \$ _____	
_____ THRU _____	_____ + _____	= _____	X _____	= \$ _____	X _____	= \$ _____	

Group Activities: \_\_\_\_\_

**TOTAL PREMIUM: \$** \_\_\_\_\_

**NOTE: Minimum Premium is \$100.00**

I certify to the best of my knowledge and belief: 1) the information above is true and correct; 2) the premium is being paid for the total number of eligible persons who are anticipated to be insured during the Policy Term; and 3) the premium is being paid entirely by the Policyholder with no contribution made by the eligible person toward the cost of the insurance.

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Title: \_\_\_\_\_

### **Eligible Events**

1. Adult Study School, Bible School.
2. Amateur Theater, Amusement Park Outing, Baton Twirling, Beauty Contest, Dance, Fashion Show, Festival, Fund-Raising Drive, Haunted House, Hay Ride, Museum Outing, Pageant, Parade, Picnic, Prom, Recital, Reunion, Zoo Outing.
3. Biathlon, Bicycling (except BMX), Boating (except Whitewater) Bowling, Exercise, Fishing, Golf, Gymnastics, Hiking, Horseback Riding, Hunting, Jogging, Marathon, Shooting Match, Skating, Soap Box Derby, Swimming, Triathlon, Volunteer Construction/Repair, Weightlifting.
4. Martial Arts, Paintball, Whitewater Rafting.
5. Air Travel, Bicycle Trip, Backpacking, Water Trip/Tour.
6. Other Land Trips or Tours.