



## 2010 – 2011 EXCESS STUDENT ACCIDENT INSURANCE COVERAGE\*

**OPTIONAL SCHOOL TIME ACCIDENT COVERAGE** - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.

**Annual Premium: Plan 4 - \$50.00**

**OPTIONAL 24-HOUR ACCIDENT COVERAGE** - Insurance coverage is provided around the clock, 24-Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).

**Annual Premium: Plan 4 - \$145.00**

**OPTIONAL FOOTBALL COVERAGE – (Up to \$25,000 Maximum)** - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterrupted to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9<sup>th</sup> graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.

**Annual Premium: Plan 4 - \$299.00**

**OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage)** – Insurance coverage is in effect 24-Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is \$25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of \$1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: \$10.00**

**COVERAGE PERIOD** – Coverage under the Optional School-Time Accident Coverage and the Optional 24-Hour Accident Coverage begins on the date of premium receipt but not before the start of the school year activities. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending activities exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted (**no pro rata premiums available**).

\*Coverage under this Policy form is not available in New York.

### SCHEDULE OF BENEFITS Coverage for Injuries due to Accident only **PLAN 4**

|   |   |
|---|---|
| <b>Maximum Benefit:</b>   |   |
| School-Time Option / 24-Hour Option / Football Option   | \$25,000  |
| Injuries Involving Motor Vehicles   | \$ 5,000  |
| Death Benefit/Double Dismemberment  | \$10,000  |
| Single Dismemberment  | \$ 5,000  |
| <b>Loss Period</b>  | Treatment must begin within 60 days from the date of Injury         |
| <b>Benefit Period</b>   | 1 Year  |
| <b>Coverage</b>   | Full Excess   |
| <b>Hospital/Facility Services - Inpatient</b>   |   |
| Hospital Room and Board   | 100% RE* for hospital semi-private room rate                        |
| Hospital Intensive Care   | 100% RE*  |
| Inpatient Hospital Miscellaneous  | \$400 1 <sup>st</sup> day/ \$350 each. thereafter / \$5,000 Maximum |
| <b>Hospital/Facility Services - Outpatient</b>  |   |
| Outpatient Hospital Miscellaneous-<br>(Except physician services and x-rays paid as below)                                | \$150 Maximum   |
| Free-standing Ambulatory Surgical Facility  | \$1,500 Maximum   |
| Hospital Emergency Room Physician   | \$60 Maximum  |
| <b>Physician's Services</b>   |   |
| Surgical  | 80% RE* to \$2,000 Maximum  |
| Assistant Surgeon   | 25% of Surgical Benefits  |
| Anesthesiologist  | 25% of Surgical Benefits  |
| Physician's Non-surgical Treatment (Except as below)  | \$25/Visit  |
| Physician's Outpatient Treatment in connection with Physical Therapy<br>and/or Spinal Manipulation                        | \$25/Visit; \$350 Maximum   |
| <b>Other Services</b>   |   |
| Registered Nurses' Services   | 100% RE*  |
| Prescriptions - outpatient  | 100% RE*  |
| X-rays, includes interpretation - outpatient  | \$250 Maximum   |
| Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation - outpatient  | \$500 Maximum   |
| Ground Ambulance  | \$300 Maximum   |
| Durable Medical Equipment (includes Orthopedic Braces & Appliances)   | \$250 Maximum   |
| Replacement of eyeglasses, hearing aids, contact lenses,<br>if medical treatment is also received for the covered injury. | \$200 Maximum   |
| Dental Treatment to sound, natural teeth due to covered injury  | \$200/Tooth   |

\*RE means Reasonable Expense  
140-50 (TX5)

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### 2010 – 2011 ENROLLMENT APPLICATION (please print or type)

Student's Last Name \_\_\_\_\_ Student's First Name \_\_\_\_\_ Student's Middle Initial \_\_\_\_\_ Grade \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Birthdate \_\_\_\_\_  
 School System \_\_\_\_\_ Name of School \_\_\_\_\_

Check your selection:  School-Time \$50.00  24-Hour Accident \$145.00  Football \$299.00  24-Hour Dental \$10.00

**Please make check payable to Sentry Life Insurance Company**

Total Enclosed: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**EXCESS COVERAGE PROVISION** Benefits will be paid only for such expense that is not recoverable from any Other Plan. We will determine the Amount of benefits provided by Other Plans without reference to any Coordination of Benefits, non-duplication of benefits, or similar provisions. The Amount from Other Plans includes any amount, to which the Insured is entitled, whether or not a claim is made for the benefits. The Student Accident plan is secondary to all other policies. This provision will not apply if the total Reasonable Expenses incurred for Hospital and Professional Services are less than the amount stated in the Schedule of Benefits under Excess Coverage Applicability.

**MEDICAL BENEFITS** When a covered Injury to a student results in treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or is Hospital confined, and treatment begins within 60 days from the date of Injury, the Company will pay benefit as shown in the Schedule of Benefits, subject to the full Excess Coverage Provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

**ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT** When a covered Injury results in any of the Losses to the student, We will pay the benefit stated in the Schedule of Benefits. The Loss must be sustained within 365 days from date of Injury. The Maximum Benefit payable under this provision is stated in the Schedule of Benefits: 1) Life; 2) Both Hands or Both Feet or the Sight of Both Eyes; 3) One Hand and One Foot; 4) One Hand and the Sight of One Eye; or 5) One Foot and the Sight of One Eye.

Half of the Double Dismemberment benefit, in the schedule will be paid for the Loss of One Hand, One Foot or the Sight of one eye.

Loss of hand or foot means the actual and complete severance through or above the wrist or ankle. Loss of sight means irrecoverable loss of sight. These Losses will be considered total and irrecoverable if such loss cannot be restored or corrected by medical or surgical treatment. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount We will pay is the Maximum Benefit.

**DEFINITIONS** **Injury** means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Insured is covered under the Policy. **Reasonable Expense** means the usual, reasonable and customary fee or charge for the services rendered and the supplies furnished in the area where and at the time such services are rendered or supplies furnished, as determined by Us. Such services and supplies must be recommended and approved by a Physician.

**EXCLUSIONS** No Benefits are payable for Hospital and Professional Services for the following:

1. Injuries which are not caused by an Accident;
2. Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis;
3. Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile;
4. Re-Injury or complications of a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a 6 month period preceding the Policy Effective Date;
5. Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid;
6. Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association;
7. Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School;
8. Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; the taking part in any illegal occupation; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or being under the influence of any drugs or narcotic unless administered by or on the advise of a Physician;
9. Medical expenses for which the Insured is entitled to benefits under any (a) Workers' Compensation act; or (b) mandatory no-fault automobile insurance contract; or similar legislation;
10. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain.

#### RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. If there is any conflict between this brochure and the Policy, the Policy will prevail. **IMPORTANT NOTICE – This Policy does not provide coverage for Sickness. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form 180-1369, underwritten by Sentry Life Insurance Company.**

#### HOW TO FILE A CLAIM

- 1) Obtain claim form from your school office or the marketing agent and answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.
- 2) If you have other insurance, submit your claim to your other insurer. When you receive the **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**, send it to us along with the corresponding **ITEMIZED BILLS** with diagnosis along with this fully completed claim form. **KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**
- 3) If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.
- 4) Mail all correspondence to Sentry Life Insurance Company, Policy Benefits, P.O. Box 8025, Stevens Point, WI 54481. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with student's name, school district and date of Accident.
- 5) If you change your address, please notify Sentry Life Insurance Company by calling 1-800-426-7234 so that there is no delay in processing any claims. Please contact Sentry Life Insurance Company by calling 1-800-426-7234 if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

**UNDERWRITTEN BY:**



**SENTRY**  
LIFE INSURANCE  
COMPANY

1800 North Point Drive, Stevens Point, WI 54481

**MARKETING AGENT:**

Texas School Insurance

P.O. Box 781227

San Antonio, TX 78278

(210) 492-7732

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To apply for coverage, please enroll on-line with a credit card at [www.k12specialmarkets.com](http://www.k12specialmarkets.com) or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.

*Please Return To:* Texas School Insurance  
P.O. Box 781227  
San Antonio, TX 78278