

SCHOOL CITY OF HAMMOND

MEMORANDUM

TO: PRINCIPALS, ADMINISTRATORS AND SECRETARIES

FROM: Terese Williams - 933-2400 EXT. 1025
BUSINESS DEPARTMENT

DATE: JULY 20, 2011

SUBJECT: STUDENT ACCIDENT INSURANCE FOR THE 2011/2012 SCHOOL YEAR

The "Student Accident Insurance" will be provided by Student Athletic Protection, Inc., 3207 Stadium Drive, Suite #7, Kalamazoo, Michigan 49008-1500. The agent to contact will be Rick Russell, Phone number is 269-375-6337 or 800-232-1579. Fax is 269-375-3103.

The premium per student is as follows:				
(See enclosed brochure for benefit descriptions)				
	REGULAR BENEFITS		DOUBLE BENEFITS	
GRADES K - 12	School Time	24 - Hour	School Time	24 - Hour
Includes all interscholastic sports- *Except senior high football	\$ 28.00	\$ 110.00	\$ 54.00	\$ 220.00
Including 24-Hour extended dental	\$ 33.00	N/A	\$ 66.00	N/A
Optional senior high football *2008 Season Only-Payable in addition to school time plan or the 24-hour plan	\$ 275.00	N/A	\$ 550.00	N/A
Great Start Life Insurance *First three months only	\$ 1.00			

The limitations to the benefits provided are covered in the student insurance envelopes.

The administration would like to encourage principals to make every effort to inform parents and students of this reasonably priced insurance. This coverage becomes very important to the parents when students are injured, especially when other family insurance is insufficient. **Some type of insurance coverage for injuries received by students at school helps alleviate legal problems for the school corporation.** Questions regarding administration of this insurance plan should be directed to Terese Williams, Director of Business Services at 219-933-2400 Ext 1025.

"Student Accident Insurance" envelopes explaining the policy are being sent to your school. There will be 100 envelope provided for each school. This policy protects students during the school day, in all school-sponsored activities, and also when they are traveling to and from school or school sponsored activities. The "24 Hour Coverage" provides protection during the summer months and when students are not in school.

This insurance does **NOT** cover high school students participating in senior high football.

Optional senior high football coverage for the 2011/2012 season only is available for the added amount of **\$ 275.00** in addition to the school time or the 24-hour coverage.

The administrative procedures in handling the "Student Accident Insurance" program are as follows:

1. Beginning with the 11-12 School Year, as stated in the Student/Parent Handbook, Student Accident enrollment forms will be available in the office, the School City of Hammond website under Parent Access or online at www.stuproinc.com under Forms. **The insurance company will not accept enrollments submitted using previous year's application envelopes.**
2. Parents are to complete the envelopes, enclose premium (Do **NOT** enclose cash) and send directly to:
Mr. Rick Russell, Local Agent
Student Athletic Protection, Inc.
3207 Stadium Drive, Suite #7
Kalamazoo, Michigan 49008-1500
Phone: 269-375-6337 or 800-232-1579
Fax: 269-375-3103
3. A copy of the "List of Insured" will be sent to each school by Student Athletic Protection, Inc. and is to be kept in the school office to verify students in need of claim forms.
4. Insurance envelopes can be accepted any time during the school year and should be sent directly to Student Athletic Protection, Inc. **Encourage parents to purchase this insurance early because the school coverage lapses at the end of the school year and the 24-hour coverage lapses at the end of the summer when school re-opens.**
5. Enclosed along with your procedures and brochures are claim forms, which are to be kept in the school office. In the event a student is injured, complete the appropriate section and give it to the student or parent for completion of section two. This form is available at the School City of Hammond website under Parent Access or online at www.stuproinc.com under forms.

The parent will then give it to their physician who will complete their portion, parent will then need to sign form and attach all itemized bills pertaining to the accident and send to Guarantee Trust Life Insurance Co. at PO Box 1148 Glenview, IL 60025 for payment 1-800-622-1993.

6. Refer all questions or problems concerning "Student Accident Insurance" to: Mr. Rick Russell at 269-375-6337 or 800-232-1579 or Terese Williams at the Administration Center in the Business Office at 219-933-2400 Ext. 1025



Student Athletic Protection

INDIANA

**2011/2012 SCHOOL YEAR
"MAIL-BACK" ENROLLMENT**

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL LYNN RUSSELL AT 800-232-1579 (email: lynnr@stuproinc.com). BETWEEN THE HOURS OF 8:30 AM & 4:00 PM EASTERN STANDARD TIME, MONDAY THROUGH THURSDAY.

DISTRIBUTION PROCEDURE
OPTIONAL INDIANA STUDENT ACCIDENT INSURANCE

1. ENROLLMENTS FOR THE 2011/2012 YEAR MUST BE APPLIED FOR USING THE 2011/2012 APPLICATION BROCHURE ENVELOPES. ***WE CANNOT ACCEPT ENROLLMENTS SUBMITTED USING PREVIOUS YEAR'S APPLICATION ENVELOPES. THEY ARE DATED AND THE PREMIUMS AND BENEFITS HAVE CHANGED.***
2. PLEASE REVIEW A 2011/2012 BROCHURE ENVELOPE. CHECK THE PREMIUM LISTED ON THE BROCHURE AS WELL AS "ITEMS NOT COVERED" (#15). THE BROCHURE CLEARLY STATES THAT "NO REFUNDS ARE AVAILABLE FOR ACCIDENT PLANS."
3. DETERMINE A DATE FOR SOLICITATION OF STUDENTS, AND MAKE BROCHURES AVAILABLE TO STUDENTS/HOMEROOM/SCHOOL/TEACHER. THE 2011/2012 STUDENT ACCIDENT INSURANCE BROCHURES ARE "MAIL-BACK" BROCHURES. ONCE THESE BROCHURES ARE MADE AVAILABLE TO THE STUDENTS, IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO RETURN THE COMPLETED BROCHURE AND APPROPRIATE PREMIUM TO STUDENT ATHLETIC PROTECTION, INC.
4. **ENROLLMENT BROCHURES ARE AVAILABLE ONLINE AT www.stuproinc.com. (Look for FORMS and find the Student Accident Enrollment Form K-12). THE APPLICATION FORM CAN BE PRINTED AND SUBMITTED TO OUR OFFICE WITH THE APPROPRIATE PREMIUM.**
5. ENROLLMENT LISTS WILL BE PREPARED BY STUDENT ATHLETIC PROTECTION, INC. A COPY OF THAT LIST WILL BE FORWARDED TO YOUR SCHOOL AND/OR ADMINISTRATION OFFICE. THIS LIST WILL BE THE OFFICIAL RECORD OF ENROLLMENTS FOR YOUR SCHOOL. ANY QUESTIONS REGARDING ENROLLMENTS MUST BE DIRECTED TO STUDENT ATHLETIC PROTECTION, INC..
6. COVERAGE IS EFFECTIVE THE DATE PREMIUM PAYMENT IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE, BUT NOT PRIOR TO THE POLICY EFFECTIVE DATE.
7. IF PREMIUM PAYMENT FOR INDIVIDUAL COVERAGE IS RECEIVED AFTER THE POLICY EFFECTIVE DATE, COVERAGE WILL BECOME EFFECTIVE AT 12:01 PM ON THE DATE PREMIUM PAYMENT IS RECEIVED BY US OR OUR REPRESENTATIVE.

PO BOX 20237 –Kalamazoo MI 49019 – 800-232-1579 or lynnr@stuproinc.com

We Recommend 24-Hour-A-Day Coverage...

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are affordable accident insurance plans to cover your child either 24 hours a day (24 hour plan) or while in school (at school plan).
- These plans provide cash benefits to help meet the cost of medical and hospital expense.
- If you have other insurance, these plans will help meet the deductibles and coinsurance gaps in those plans.
- If you have no other insurance, these plans will provide low cost, basic coverage.

24-Hour-A-Day Protection (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 travel (see Exclusions and Limitations)

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

At School Protection

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 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.

24-HR-A-DAY	AT SCHOOL	IMPORTANT PROTECTION FACTS
✓	✓	BECOMES EFFECTIVE THE DATE PREMIUM PAYMENT IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE (but not prior to the opening day of school).
✓	✓	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 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 COVERAGE BEGINS ON THE DATE OF PREMIUM RECEIPT BY THE COMPANY, 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.

SA-15

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 THE COMPANY WITHIN 90 DAYS.

PROTECT YOUR CHILD FOR LIFE!

Very affordable life insurance for your child

FOR NOW AND THROUGHOUT THEIR GROWING YEARS, THE GREAT START PLAN PROVIDES ALL THE BASIC LIFE INSURANCE YOU NEED ON YOUR CHILD UP TO \$10,000 FOR THEIR FUTURE. DEPENDING ON YOUR ORIGINAL POLICY YOUR ADULT CHILD CAN INCREASE THEIR ORIGINAL \$10,000 COVERAGE TO A FULL \$40,000. JUST CHECK (✓) THE BOX FOR LIFE INSURANCE AND SELECT THE AMOUNT YOU WANT FOR YOUR CHILD AS YOU SIGN UP FOR ACCIDENT PROTECTION. YOUR CHILD IS FULLY INSURED FROM THE DAY YOUR POLICY IS APPROVED AND ISSUED. THE ONLY EXCLUSION IS SUICIDE IN THE FIRST 2 YEARS (4 YEAR IN CO AND ND, N/A IN MO). THIS POLICY PROVIDES BASIC LIFE INSURANCE UNTIL YOUR CHILD REACHES AGE 26. AT AGE 26, THE POLICY CONTINUES AS CASH VALUE WHOLE LIFE INSURANCE. CHILDREN AGES 3 MONTHS TO 25 YEARS ARE ELIGIBLE TO APPLY. SIMPLY COMPLETE AND SIGN THE APPLICATION FORM. POLICIES ARE AVAILABLE FOR \$5,000 AND \$10,000 BENEFIT AMOUNTS. THE RATES ARE \$30 A YEAR FOR A \$5,000 POLICY AND \$50 A YEAR FOR A \$10,000 POLICY AT AGE 26. THE RATES CHANGE TO \$80 PER YEAR FOR A \$5,000 POLICY AND \$150 PER YEAR FOR A \$10,000 POLICY. THESE RATES ARE GUARANTEED TO REMAIN THE SAME FOR LIFE.

Why not take a positive step to PROTECT YOUR CHILD FOR LIFE? \$1 for the first 3 month's coverage. Very affordable life protection. APPLY TODAY!

1

FOR FIRST 3 MONTHS

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

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES FROM ACCIDENTAL BODILY INJURY
- 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 SPECIFIED BELOW.

COVERAGE and BENEFITS

Policy benefits for eligible expense incurred will be paid up to the first \$100. After taking this initial payment into account, benefits will then be paid on an excess basis if there are other coverages or plans that would provide benefits for the same injury.

BENEFITS EACH ACCIDENT		LOW OPTION	HIGH OPTION
INPATIENT HOSPITAL EXPENSE Confinement must begin within 26 weeks of injury	HOSPITAL CARE AND SERVICE, Includes all items of expense, including outpatient surgery requiring the use of general anesthetics.	Semi-private room rate up to \$300.00 per day	Semi-private room rate up to \$600.00 per day
OUTPATIENT HOSPITAL EXPENSE	HOSPITAL OR EMERGENCY CARE FACILITY	\$75.00	\$150.00
SURGERY (Includes suturing, cutting and reduction of fractures)	DOCTOR'S FEE, Per Unit Value Determined by a Relative Value Schedule* *Example: Craniotomy Fracture, Metatarsal	\$70.00 \$1,015.00 \$105.00	\$140.00 \$2,030.00 \$210.00
DOCTOR FEES Non-surgical	ANESTHETIST, Percent of Surgical Allowance	25%	25%
	PER VISIT (Includes physiotherapy, diathermy, heat treatment, manipulation or massage) Maximum number of visits	\$25.00	\$50.00
OUTPATIENT IMAGING PROCEDURES Including X-rays and interpretation		\$70.00	\$140.00
AMBULANCE EXPENSE		\$350.00	\$700.00
DENTAL EXPENSE	Treatment for injury to sound, natural teeth.	\$100.00	\$200.00
	PER TOOTH		

PROTECT YOUR CHILD, PROTECT YOURSELF.

Here are your 2011-2012 Student Insurance Plans:

COVERAGE and BENEFITS (continued)

BENEFITS EACH ACCIDENT		
OTHER BENEFITS Only one of these benefits, the largest, will be payable in addition to the benefits shown GP-1200 (IN)	ACCIDENTAL DEATH caused by an injury and occurring within 90 days of the covered accident DISMEMBERMENT caused by an injury and occurring within 90 days of the covered accident Sight of one eye Either hand or foot Any combination of hands, feet or eyes	\$1,000.00 \$1,000.00 \$2,500.00 \$5,000.00

EXTENDED DENTAL BENEFIT OPTION Full time dental coverage may be added to the AT-SCHOOL PLAN. You have the option of extending dental coverage to 24-Hours-A-Day, year round. PLEASE NOTE: This benefit is already included in the 24-HOUR PLAN.

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, or are not specifically listed as covered charges in the policy.
2. Injury by acts of war, whether declared or not.
3. Injury covered by Worker's Compensation or the Occupational Disease Law.
4. Treatment of hernia.
5. Re-injury or complications of an injury which occurred prior to the policy's effective date.
6. Dental treatment, except as specifically stated.
7. Eyeglasses or prescriptions therefor.
8. Injury sustained while voluntarily participating in a riot or civil commotion.
9. Injury which is self-inflicted, or caused by the Insured's own words or actions.
10. Loss resulting from private air travel.
11. Prescription drugs, crutches, braces, artificial limbs etc.
12. Treatment of sickness or disease in any form, mental derangement or neurasthenia, blisters, insect bites, frostbite, heat exhaustion or sunstroke.
13. Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts.
14. Injury sustained while skiing, except as an interscholastic sport.
15. 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).
16. Injury sustained while participating in or practicing for senior high school interscholastic football, unless optional coverage is purchased.
17. Loss covered by other valid and collectible group or automobile medical payment coverage on claims where medical expense exceeds \$100.00.

LIMITATION - Medical expenses for injuries sustained in an accident involving a motor vehicle are limited as provided under "At School - Important Protection Facts" up to a maximum of \$5,000.00. This does not apply to motor vehicles which are excluded from coverage.

The Master Policy is on file with your School.

This is an illustration. This is not a contract. Please keep for your records.

Administered by STUDENT ATHLETIC PROTECTION, INC.
PO BOX 20237, KALAMAZOO, MI 49019 (800) 232-1579
Underwritten and Claims Paid by Guarantee Trust Life Insurance Co.
For Claim Service Please Call: (800) 622-1993

2011-12 SCHOOL YEAR APPLICATION

0239

Student Insurance Application to: Guarantee Trust Life Insurance Company, Glenview, Illinois

PLEASE PRINT CLEARLY

School _____ District _____ Grade _____

Person to be insured: First Name _____ Middle Initial _____ Last Name _____ Zip Code _____

Address: No. and Street _____ City _____ State _____ Phone No. () _____

Age _____ Date of Birth: Month _____ Day _____ Year _____ Male Female

OPTIONS	LOW OPTION	HIGH OPTION
24-Hour-A-Day Protection	<input type="checkbox"/> \$110.00	<input type="checkbox"/> \$220.00
At School Protection	<input type="checkbox"/> \$28.00	<input type="checkbox"/> \$54.00
At School Protection with EXTENDED DENTAL OPTION	<input type="checkbox"/> \$33.00	<input type="checkbox"/> \$66.00
OPTIONAL SENIOR HIGH FOOTBALL 2011 Season Only Payable in addition to 24-Hour Plan or At School Plan	<input type="checkbox"/> \$275.00	<input type="checkbox"/> \$550.00
NO REFUNDS ARE AVAILABLE FOR ACCIDENT PLANS		
GREAT START® Life Insurance Protection (May be selected with or without other plans) Pick an Amount: <input type="checkbox"/> \$1,000.00 <input type="checkbox"/> \$10,000.00		

TOTAL ENCLOSED \$ _____
(Please do **NOT** send cash)
MAKE CHECK PAYABLE TO: STUDENT ATHLETIC PROTECTION, INC. L-53

***COMPLETE THIS SECTION IF A MODIFIED WHOLE LIFE POLICY WITH 3 MONTHS PRELIMINARY TERM IS DESIRED.**

Mail Policy and Premium Notice to: First Name _____ Middle Initial _____ Last Name _____
 Has the person to be insured, within the last 5 years, had or received medical treatment or advice for: high blood pressure, heart trouble, cancer or tumor, kidney trouble, diabetes, epilepsy, birth defects, drug or alcohol abuse or a sexually transmitted disease? No Yes
 Within the past 5 years, has the person to be insured been diagnosed by a medical doctor as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the presence of the Human Immunodeficiency Virus (HIV)? No Yes
 Is this insurance meant to replace any existing insurance or annuities with any company? No Yes
 If answer is yes, list company name and address _____
 To the best of my knowledge and belief, the above answers are true and correct. I understand that I am the Policy's Owner and Beneficiary, unless another Beneficiary is named. I also understand the insurance is not effective until October 15, 2011, or the date the application is received by the company or its representatives, if later. Any life insurance premium will be refunded if the policy is not issued.

Date _____ Signature _____
 Relationship to Insured: Self Grandparent Parent Guardian Other

PLEASE REMEMBER TO:

COMPLETE THE APPLICATION 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 APPLICATION WITH YOUR CHECK OR MONEY ORDER TO:

STUDENT ATHLETIC PROTECTION, INC.
 PO BOX 20237
 KALAMAZOO, MI 49019

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

Please read these instructions carefully:

HOW TO REPORT A CLAIM/INJURY OPTIONAL *INDIANA* STUDENT ACCIDENT INSURANCE

1. A SUPPLY OF CLAIM FORMS IS PROVIDED AND CAN BE KEPT AVAILABLE IN THE OFFICE OF THE SCHOOL OFFICIAL DESIGNATED TO REPORT CLAIMS. THE CLAIM FORM CAN BE DUPLICATED IF ADDITIONAL FORMS ARE NEEDED.
2. ONLY ONE CLAIM FORM NEEDS TO BE COMPLETED FOR EACH ACCIDENT.
3. FOR SCHOOL-TIME ACCIDENTS, VERIFY THAT THE STUDENT HAS COVERAGE, COMPLETE THE SCHOOL PORTION OF THE CLAIM FORM, AND GIVE IT TO THE STUDENT (OR PARENT/GUARDIAN) FOR COMPLETION.
4. FOR 24 HOUR COVERAGE CLAIMS (ACCIDENTS OCCURRING OUTSIDE OF SCHOOL) YOU DO NOT NEED TO VERIFY COVERAGE, SIMPLY PROVIDE THE STUDENT (OR PARENT/GUARDIAN) WITH A CLAIM FORM FOR COMPLETION.
5. INSTRUCT THE STUDENT (OR PARENT/GUARDIAN) TO SEND THE COMPLETED CLAIM FORM WITH ALL ITEMIZED BILLS PERTAINING TO THE ACCIDENT TO GUARANTEE TRUST LIFE INS. CO. AT THE ADDRESS BELOW.
6. PAYMENT WILL BE MADE DIRECTLY TO THE PROVIDER UNLESS RECEIPTS OR CANCELED CHECKS ARE AVAIABLE, IN WHICH CASE THE PARENT/GUARDIAN WILL BE PAID DIRECTLY.

THE COMPLETED CLAIM FORM SHOULD BE SENT TO:

ATTN. SPECIAL RISK CLAIMS
GUARANTEE TRUST LIFE INS. CO.
PO BOX 1148
GLENVIEW IL 60025
800-622-1993

SCHOOL NAME:	<i>IMPORTANT! All required information must be given or claim will be returned!!</i>	<i>Return completed form to:</i> Guarantee Trust Life Ins. Co. PO BOX 1148 Glenview IL 60025 800-622-1993
Assignment of Benefits: Dr. _____ Addr.: _____ _____ City State Zip	Hosp.: _____ Addr.: _____ _____ City State Zip	Other: _____ Addr: _____ _____ City State Zip

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

DATE: _____ Signature of Parent/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 _____ DOB ___/___/___ 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 it occurred? _____
 _____ (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. Claimant's Social Security Number: _____
10. Do you have other insurance, which covers this condition, either group, individual, automobile medical or liability? Yes ___ No ___
 If yes, give Company Name and Phone Number _____ Policy # _____
11. Parent's name: Father _____ Mother _____
 Employer's Name: _____
 Employer's Address: _____

Note: Your State Insurance Department requires us to notify you that: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Authorization: I hereby authorize Guarantee Trust Life Insurance Company, or it's representatives, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, X-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. I understand that I or my authorized representative is entitled to copy of this authorization by request.

SIGNATURE _____ **DATE** _____ **ADDR** _____
 (Parent/Guardian or claimant if an Adult)
 GCF-IN (06/08)SAP



Student Athletic Protection
PO BOX 20237
KALAMAZOO MI 49019
800-232-1579

July 2011

The student accident brochures are available online at www.stuproinc.com. They are located in the forms section. To enroll you must print out the brochure, carefully read the instructions, and send the completed application along with the appropriate premium to Student Athletic Protection, Inc., PO Box 20237, KALAMAZOO MI 49019.

Please note that OPTIONAL SENIOR HIGH FOOTBALL is for the 2011 Season Only and is payable in addition to the 24-Hour Plan or At School Plan.

No refunds are available for accident plans.

An outline of coverage and benefits is included in the brochure.

Please call Student Athletic Protection, Inc. at the number listed above if you have further questions.

The Administrative Procedure for Student Accident Insurance (Athletic)

The administrative procedures in handling the "Student Accident Insurance" program are as follows:

1. Every coach is to send home the Athletic Department Statement of Insurance Wavier Form with each student. Please include any information you would like to add. **Make sure each child has a form completed and kept on file with the Athletic Director for each sport.**
2. Parents are to complete the envelopes, enclose premium and send directly to:
Mr. Rick Russell, Local Agent
Student Athletic Protection, Inc.
3207 Stadium Drive, Suite #7
Kalamazoo, Michigan 49008-1500
Phone: 269-375-6337 or 800-232-1579
Fax: 269-375-

A copy of the "List of Insured" is to be kept in the school office to verify claims.

3. Insurance envelopes can be accepted any time during the school year and should be sent directly to Student Athletic Protection, Inc. **Encourage parents to purchase this insurance early because the school coverage lapses at the end of the school year and the 24-hour coverage lapses at the end of the summer when school re-opens.**
4. You will receive claim forms, which are to be kept in the school office. In the event a student is injured, complete the appropriate section and give it to the parent for completion of section two.

The parent will then give it to their physician who will complete their portion, parent will then need to sign form and attach all itemized bills pertaining to the accident and send to Guarantee Trust Life Insurance Co. at PO Box 1148 Glenview, IL 60025 for payment 1-800-622-1993.

5. Refer all questions or problems concerning "Student Accident Insurance" to:
Mr. Rick Russell at 269-375-6337 or 800-232-1579 or Karen Wallisch at the Administration Center.

SCHOOL CITY OF HAMMOND ATHLETIC DEPARTMENT STATEMENT OF INSURANCE 2011 – 2012

Dear Parent:

Your son or daughter is going out for _____ at _____ Middle School and we would like to make you aware of the protection that is available to you if your son/daughter is injured and needs medical care. A student accident insurance plan is available to our students at a very reasonable premium, \$28.00. This insurance plan covers medical expenses for injuries received while involved in school time activities **including middle school athletics**. This policy also has the option to included 24-hour extended dental at a higher (\$33.00) per student. This policy also offers a 24-hour option at a higher premium (\$110.00) per student, which covers the student around the clock for a full year. This is a limited policy, but is relatively comprehensive for the low premium charge. Study the premium sheet printed on the back of this letter carefully to become familiar with the coverage and exclusions. A premium envelope will be sent out in August during the first week of school. It will list all coverage, exclusions, and procedures to be used in filing a claim. The school time coverage is effective the date premium payment is received by Student Athletic Protection, Inc., but not prior to August 1, 2011, and ends on the last of school. The 24-hour coverage is effective the date premium payment is received by Student Athletic Protection, Inc., but not prior to August 1, 2011, and ends July 31, 2012. These plans are available to purchase during any part the school year if you choose.

PARENTS: Please fill in student's name and sign under the insurance statement (1, 2 or 3) below that applies to your child.

1. We have examined carefully our family accident, medical and hospital policies and find that they **DO** cover injuries that do occur in the School's Athletic Program.

Student's Name _____

Date _____

Parent's Signature _____

2. We **DO NOT** have adequate accident insurance to cover our son/daughter in case of an athletic injury and we **WILL** subscribed to the \$28.00, \$33.00/Dental or \$110.00 student accident plan.

Student's Name _____ Social Security # ____ - ____ - ____ Birth Date ____ / ____ / ____

Address _____ Apt# _____ Phone _____

City _____ State _____ Zip _____

Parent's Signature _____

Date _____

3. We **DO NOT** have adequate family *insurance* and we **DO NOT** wish to purchase this student accident plan. **We realize that we assume full financial responsibility for injuries received by our child.**

Student's Name _____

Date _____

Parent's Signature _____

SCHOOL CITY OF HAMMOND ATHLETIC DEPARTMENT INSURANCE 2011 – 2012

Dear Parent:

Your son or daughter is going out for _____ at _____
High School and we would like to make you aware of the protection that is available to you if your son/daughter is injured and needs medical care. A student accident insurance plan is available to our students at a very reasonable premium, \$28.00. This insurance plan covers medical expenses for injuries received while involved in school time activities **including high school athletics* except High School Football which is covered at \$275.00**. This policy also has the option to included 24-hour extended dental at a higher (\$33.00) per student. This policy also offers a 24-hour option at a higher premium (\$110.00) per student, which covers the student around the clock for a full year. This is a limited policy, but is relatively comprehensive for the low premium charge. Study the premium sheet printed on the back of this letter carefully to become familiar with the coverage and exclusions. A premium envelope will be sent out in August during the first week of school. It will list all coverage, exclusions, and procedures to be used in filing a claim. The school time coverage is effective the date premium payment is received by Student Athletic Protection, Inc., but not prior to August 1, 2011, and ends on the last of school. The 24-hour coverage is effective the date premium payment is received by Student Athletic Protection, Inc., but not prior to August 1, 2011, and ends July 31, 2012. These plans are available to purchase during any part the school year if you choose.

PARENTS: Please fill in student's name and sign under the insurance statement
(1, 2 or 3) below that applies to your child.

1. We have examined carefully our family accident, medical and hospital policies and find that they **DO** cover injuries that do occur in the School's Athletic Program.

Student's Name _____

Date _____

Parent's Signature _____

4. We **DO NOT** have adequate accident insurance to cover our son/daughter in case of an athletic injury and we **WILL** subscribed to the \$28.00, \$33.00/Dental, \$110.00/24-Hour, or \$275.00/Senior high football student accident plan.

Student's Name _____ Social Security # ____ - ____ - ____ Birth Date ____/____/____

Address _____ Apt# _____ Phone _____

City _____ State _____ Zip _____

Parent's Signature _____

Date _____

5. We **DO NOT** have adequate family *insurance* and we **DO NOT** wish to purchase this student accident plan. **We realize that we assume full financial responsibility for injuries received by our child.**

Student's Name _____

Date _____

Parent's Signature _____

INDIANA STUDENT ACCIDENT INSURANCE

2011/2012

<u>BENEFIT</u>	<u>REGULAR BENEFIT</u>	<u>DOUBLE</u>
Medical Maximum	\$25,000.00	\$25,000.00
Accident Death	\$ 1,000.00	\$ 1,000.00
Dismemberment Schedule	\$ 5,000.00	\$ 5,000.00
Hospital Inpatient Expense & Outpatient Surgery requiring general Anesthetic	Semi-private up to \$300/day	Semi-private up to \$600/day
Outpatient	\$75.00 Emergency Room	\$150.00 Emergency Room
Surgical Charges (Doctor's)	1974 5 th Edition Revised Relative Value Schedule \$ 70.00/Unit	1974 5 th Edition Revised Relative Value Schedule \$ 140.00/Unit
Anesthesia	25% of the schedule	25% of the schedule
Doctor's charges w/out surgery & for injuries requiring physiotherapy, Diathermy, heat treatment in any form, Manipulation or massage	\$25.00 per visit up to five total	\$ 50.00 per visit up to five total
Outpatient Diagnostic X-rays Including interpretation	One X-ray up to \$ 70.00	One X-ray up to \$ 140.00
Dental, per whole, sound; Natural, tooth	\$ 100.00 per tooth	\$ 200.00 per tooth
Ambulance	\$ 350.00 limit	\$ 700.00 limit
Excess Provisions	First \$100.00 primary, Then excess	First \$100.00 primary, Then excess

<u>RATES</u>	<u>REGULAR BENEFIT</u>		<u>DOUBLE BENEFIT</u>	
	SCHOOLTIME	24-HOUR	SCHOOLTIME	24-HOUR
Plan III				
Includes all interscholastic sports- Except senior high football	\$ 28.00	\$ 110.00	\$ 54.00	\$ 220.00
Including 24-hour extended dental	\$ 33.00	N/A	\$ 66.00	N/A
Sr. High Football- optional	\$ 275.00	N/A	\$ 550.00	N/A
Great Start Life Insurance *First three months only	\$ 1.00			