

Student Accident Insurance

for Public Schools



UNDERWRITTEN BY:



COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

PRESENTED BY:

GENE WEBER AGENCY

1542 S. Wickham Road
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PLAN 1

All School Plan

Blanket coverage on all enrolled students and/or children from Pre-School to Senior High.

This plan is available to those desiring to provide benefits to all its enrolled students in grades Preschool–12. This plan gives an administrator peace of mind knowing all students are protected for any school athletic (*INCLUDING FOOTBALL*) and non-athletic activity.

PREMIUM SCHEDULE

**The premium in grades Preschool–12 for students regularly enrolled in the school/center division, is as follows:
\$500 minimum premium required for School-time Coverage.**

	High Option	Low Option
Students	\$12.50	\$ 7.25

Under this Plan all enrolled students for whom the premium has been paid are insured . . .

1. While on the school/center premises during a period of regular attendance on the days when school is in session.
2. While traveling directly to or from the Insured's residence and school for regular sessions, for such travel time as may be necessary (one hour before school begins and one hour after dismissal; longer if school bus requires).
3. While participating in or attending all activities sponsored by the school/center and directly and continuously supervised by a school official or employee, including supervised travel by school furnished transportation, directly to and from school activities.
4. While attending religious classes, either on or away from the school/center premises, including travel directly to or from the Insured's residence or school and the place where such classes are held.

MEDICAL BENEFITS—UP TO \$25,000.00

THE POLICY WILL PAY UP TO \$25,000.00 for medical expenses incurred as the result of covered injuries sustained by an Insured in any one accident which occurs on or after the effective date of coverage. Benefits will be paid for treatment, care and service performed within 52 weeks after the date of accident, not to exceed the Expense Benefit Limitations stated below, provided the first such expense is incurred within 30 days after the accident, subject to the "Excess Limitation."

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits are payable IN ADDITION to Medical Expense Benefits.

If a covered injury causes loss within 100 days of the accident, the policy will pay:

Loss of Life	\$ 2,000.00	Loss of One Hand and One Foot; or One Hand and One Eye; or
Loss of Both Hands, Both Feet or Both Eyes	\$10,000.00	One Foot and One Eye
Loss of One Hand or One Foot	\$ 2,000.00	Loss of Sight of One Eye
		\$ 4,000.00
		\$ 1,500.00

EXCLUSIONS AND LIMITATIONS—See Page 5.

MEDICAL EXPENSE BENEFIT LIMITATIONS Benefits are paid up to the following maximums per injury, unless otherwise stated:

	HIGH OPTION	LOW OPTION
Hospital Inpatient Expense Room & Board	Semi-Private	Semi-private
Hospital Ancillary Charges	80% U&C	\$1,500 per accident
Hospital Outpatient Emergency Care Expense (within 72 hours of injury)	80% U&C	\$ 75.00 per accident
Hospital Outpatient Surgery Expense	80% U&C	\$150.00 per accident
Physician (Non-Surgical) Office Visit	80% U&C	\$ 25.00 first visit; \$ 25.00 per visit thereafter
Physician Expense (Surgical)	80% U&C	\$150.00 per unit allowance under the current California Relative Value Studies, up to \$1,000.00
Assistant Surgeon Expense	20% of surgeon's allowance	20% of surgeon's allowance
Anesthetist Expense	20% of surgeon's allowance	20% of surgeon's allowance
Private Duty Nursing Expense	80% U&C	80% U&C
Dental Treatment of Sound Natural Teeth	80% U&C	\$150.00 per tooth; up to \$450.00 maximum per accident
Physical Therapy Expense (Inpatient and Outpatient)	80% of U&C up to a maximum of 6 visits	\$100.00 per accident
Diagnostic Surgery Expense	80% U&C	\$500.00 per accident
Diagnostic Imaging Expense	80% U&C	\$300.00 per accident
X-Ray Expense (Inpatient and Outpatient)	80% U&C	\$150.00 per accident for fracture; \$ 75.00 for non-fracture
Injury Caused by Motor Vehicle, Expense	\$500.00 per accident	\$500.00 per accident
Aggravation or Re-Injury Expense	\$500.00 per accident	\$500.00 per accident
Ambulance Expense	80% U&C	\$200.00 per accident

PLAN 2

All Athletic Plan

This plan is available only if the School District participates in the Individual Voluntary Student Insurance Program (Plan 3).

PREMIUM SCHEDULE			
\$500 minimum premium required			
All Athletic Plan	Elite Plan	Superior Plan	Economy Plan
Grades 6–8	\$17.20	\$11.85	\$ 6.85
*Grades 9–12	\$51.00	\$35.15	\$20.65
*Includes interscholastic football in or with Grades 10–12.			

WHO IS COVERED—A student is covered while practicing for or competing in all interscholastic athletic events as a member of the school team when such events are sponsored by the school and directly and continuously supervised by a school official or employee, including supervised travel by school furnished transportation, directly to and from such events.

MEDICAL BENEFITS—UP TO \$25,000.00

THE POLICY WILL PAY UP TO \$25,000 for covered expenses incurred as the result of Accidental Bodily Injury sustained in any one accident which occurs on or after the effective date of coverage. The first such expense must be incurred within 30 days of the accident and the covered treatment, care or service rendered within 52 weeks of the accident. Benefits for covered expenses shall not exceed the specified amounts. The first \$100 of covered expenses incurred as a result of each covered accident claim will be paid, regardless of any other insurance. If expenses exceed \$100, the claim will then be paid on **AN EXCESS BASIS**, if other insurance or medical service plans are involved (see **LIMITATIONS**). All benefits are per accident, unless otherwise specified.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits are payable IN ADDITION to Medical Expense Benefits.

If a covered injury causes loss within 100 days of the accident, the policy will pay:

Loss of Life	\$ 2,000.00	Loss of One Hand and One Foot; or One Hand and One Eye; or One Foot and One Eye	\$ 4,000.00
Loss of Both Hands, Both Feet or Both Eyes	\$10,000.00	Loss of Sight of One Eye	\$ 1,500.00
Loss of One Hand or One Foot	\$ 2,000.00		

EXCLUSIONS AND LIMITATIONS—See Page 5.

MEDICAL EXPENSE BENEFIT LIMITATIONS Benefits are paid up to the following maximums per injury, unless otherwise stated:			
	ELITE PLAN	SUPERIOR PLAN	ECONOMY PLAN
Policy Maximum per covered accident	\$25,000.00	\$25,000.00	\$25,000.00
Deductible	None	None	None
Physician (Non-surgical) outpatient visit	80% of U&C***	\$50.00 per treatment	\$25.00 per treatment
Surgery (Payable according to CRVS** or U&C***)	80% of U&C Max. \$8,000.00	\$175.00 unit value	\$125.00 unit value
Anesthesiologist (Percent of surgery allowance)	25%	25%	25%
Assistant Surgeon (Percent of surgery allowance)	20%	20%	20%
Hospital Inpatient room and board	Semi-private Room Rate	\$400.00 per day	\$200.00 per day
Hospital Intensive Care room and board	\$1,000.00 per day	\$400.00 per day	\$200.00 per day
Inpatient Hospital ancillary medical expenses	\$2,000.00	\$1,500.00	\$1,000.00
Outpatient Hospital Care and Service	\$300.00	\$150.00	\$100.00
Outpatient Surgical Facility	\$900.00	Paid as Outpatient Hospital Care	Paid as Outpatient Hospital Care
Radiology (excluding MRIs and Cat Scans)	80% of U&C to \$250.00	\$180.00	\$90.00
Diagnostic Imaging (MRIs, Cat Scans, etc.)	80% of U&C to \$800.00	\$400.00	\$200.00
Nurse Service	U&C	U&C	U&C
Dental Treatment of sound natural teeth	\$400.00 per tooth	\$350.00 per tooth	\$175.00 per tooth
Professional Ambulance Service	\$500.00	\$250.00	\$125.00
Physiotherapy	\$50.00 per visit Max. 5 visits	\$40.00 per visit Max. 5 visits	\$20.00 per visit Max. 5 visits
Orthopedic Appliances	\$250.00	\$150.00	\$75.00
Eyeglasses, contact lenses, and hearing aid replacement, when medical treatment is required for a covered accident	\$200.00	\$50.00	\$25.00
Injury caused by Motor Vehicle, Expense	\$500.00 per accident	\$500.00 per accident	\$500.00 per accident
***"CRVS" is the California Relative Value Studies, Fifth Edition.			
***"U&C" means usual and customary charges in the area where the treatment or service is provided.			

PLAN 3

Primary Individual Voluntary Student Plan

PREMIUM SCHEDULE

	Enrollment Options	Schoolltime Coverage	24-Hour Coverage	High School Football Coverage Grades 9–12
Grades N–12—Per Student Rates	Low Option	\$ 8.00	\$35.00	\$ 68.00
	High Option	\$18.00	\$67.00	\$130.00

Optional Extended Dental Coverage: Increases the Dental Treatment benefit under the plans to a maximum of \$1,000.00 per tooth. Coverage is effective 24 hours a day, even when selected with Schoolltime Coverage and ends on the opening day of the following Fall Term. **Premium: \$6.00.**

Parents can choose from two convenient payment methods—check or money order.

SCHOOLTIME PLAN—\$25,000.00 Maximum Medical Benefit

All enrolled students for whom premium has been paid are insured . . .

1. While on the school premises during a period of regular attendance on the days and months when school is in session.
2. While traveling directly to or from the Insured's residence and school for regular sessions, for such travel time as may be necessary (one hour before school begins and one hour after dismissal; longer if school bus requires).
3. While participating in or attending activities sponsored solely by the school and directly and continuously supervised by a school official or employee, including all sports, except interscholastic tackle football played in or with grades 9–12 (unless enrolled under such coverage and the proper premium has been paid), and including supervised travel by school furnished transportation, directly to and from school activities.
4. While attending religious classes either on or away from the school premises, including travel directly to or from the Insured's residence or school and the place where such classes are held.

Coverage is effective from the date the parent's application and premium are received by the school or the insurance company, but in no event prior to the opening day of school. Coverage terminates at 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 PLAN—\$25,000.00 Maximum Medical Benefit

. . . Extends the SCHOOLTIME Plan for a full 24 hours a day, at home or at play—anytime, anywhere, whether school is in session or not. The insured has continuous protection from the date the parent's application and premium are received (or on the opening day of school, if later) to the opening day of the next fall term.

FOOTBALL COVERAGE—

Coverage for Interscholastic Tackle Football played in or with Grades 9–12 may only be purchased in conjunction with Schoolltime or 24-Hour Insurance. Football coverage may NOT be purchased alone. Coverage includes travel to or from a football game or practice, as a team member, when such travel is sponsored by the school and solely supervised by school employees. Coverage begins on the first day of regularly scheduled school-sponsored practice, provided the student is enrolled for Football Coverage and premium is paid prior to commencement of practice. An enrollment list and/or enrollment envelopes showing the names of all Football players to be insured and the premium must be received by the Company's Agent within five (5) days after the first practice; otherwise coverage is effective on the date premium is paid. Coverage expires on July 1 of the year next following the policy effective date.

MEDICAL BENEFITS—Up to \$25,000.00

THE POLICY WILL PAY UP TO \$25,000 for medical expenses incurred as the result of covered injuries sustained by an Insured in any one accident which occurs on or after the effective date of coverage. Benefits will be paid for treatment, care and service performed within 52 weeks after the date of accident, not to exceed the Expense Benefit Limitations stated below, provided the first such expense is incurred within 30 days after the accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS—SAME AS PLAN 1—ALL SCHOOL PLAN

See Page 5 for **EXCLUSIONS** and **APPLICABLE LIMITATIONS** (B–D only)

EXPENSE BENEFIT LIMITATIONS Benefits are paid up to the following maximums per injury, unless otherwise stated:

	HIGH OPTION	LOW OPTION
Hospital Inpatient Expense Room & Board	\$250.00 per day	\$150.00 per day
Hospital Ancillary Charges	\$1,500.00 per accident	\$750.00 per accident
Hospital Outpatient Emergency Care Expense (within 72 hours of injury)	\$ 75.00 per accident	\$ 40.00 per accident
Hospital Outpatient Surgery	\$250.00 per accident	\$150.00 per accident
Physician Expenses (Non-Surgical)	\$ 30.00 per visit	\$ 20.00 per visit
Where treatment principally involves physiotherapy, limited to	3 visits	3 visits
Physician Expense (Surgical)	\$130.00 per unit allowance under the current California Relative Value Studies, up to \$800.00 per accident	\$ 90.00 per unit allowance under the current California Relative Value Studies, up to \$500.00 per accident
Assistant Surgeon's Expense	20% of Surgeon's allowance	20% of Surgeon's allowance
Anesthetist Expense	25% of Surgeon's allowance	25% of Surgeon's allowance
Private Duty Nurse Expense	80% of charges	80% of charges
Outpatient X-Ray Expense	\$100.00 per accident	\$ 50.00 per accident
Outpatient Laboratory Expense	\$ 50.00 per accident	\$ 25.00 per accident
Dental Treatment of Sound and Natural Teeth	\$100.00 per tooth; up to	\$100.00 per tooth; up to
	\$300.00 per accident	\$300.00 per accident
Ambulance Expense	\$100.00 per accident	\$100.00 per accident
Aggravation or Re-Injury Expense	\$500.00 per accident	\$500.00 per accident
Injury Caused by Motor Vehicle, Expense	\$500.00 per accident	\$500.00 per accident
Diagnostic Surgery Expense	\$500.00 per accident	\$500.00 per accident
Diagnostic Imaging Expense	\$200.00 per accident	\$100.00 per accident

EXCLUSIONS

These plans do not cover, nor is any premium charged for . . .

1. Injuries resulting from (a) the practice or play of interscholastic tackle football in or with grades 9–12, unless the proper additional premium per player has been paid; or (b) skiing in any form, except as a covered member of an interscholastic skiing team, or when 24-Hour coverage is purchased; (c) summer recreational and camp programs unless 24-Hour coverage is purchased.
2. Eyeglasses or contact lenses or prescriptions therefor, or drugs and medications, except when hospital confined; or braces, orthopedic appliances, orthodontics or durable medical equipment, except as provided in the Benefit Schedule.
3. Intentionally self-inflicted injury; or injuries occurring while violating or attempting to violate any duly enacted law.
4. Illness, disease or infection in any form, except pyogenic infection or bacterial infection due to accidental ingestion of contaminated material; hernia in any form, unless due to a covered accident.
5. Treatment administered by any person employed or retained by the school or by a member of the Insured's immediate family.
6. Injuries sustained while operating, riding in or on, or alighting from a 2- or 3-wheeled engine-driven or motorized vehicle, or any vehicle not designed primarily for use on public streets and highways.
7. For accidents involving other motor vehicles, medical expenses in excess of \$500.00.
8. Air travel or the use of any device or equipment for aerial navigation, except as a fare-paying passenger on a regularly scheduled commercial airline.
9. Loss covered by Workers' Compensation or Employer's Liability Act or Law.
10. Injury resulting from intoxication or the use of drugs or narcotics, unless administered on the advice of a physician.
11. Injuries resulting from war or act of war, participation in any riot or civil commotion; nuclear reaction or radiation.
12. Reinjury or complications of a condition due to accidental bodily injury occurring prior to the effective date of coverage in excess of \$500.00.

LIMITATIONS

- A. **EXCESS LIMITATION: Plan 1** is designed to pay on an excess basis, that is, no payment will be made for expenses for which hospital, medical, surgical or dental benefits are payable or service is available under any other insurance or medical service plan, including HMO's, PPO's, Workers' Compensation and similar plans. **Plan 2** is designed to pay on a primary/excess basis, that is, no payment shall be made for expenses in excess of \$100.00 per accident for which hospital, medical, surgical or dental benefits are payable or service is available under any other insurance or medical service plan, including HMO's, PPO's, Workers' Compensation, Employer's Liability Act or Law, Automobile No-Fault and similar plans.
- B. No benefits are payable for any expense resulting from participation in interscholastic activities for which benefits would be payable, in the absence of insurance hereunder, under any High School Association Catastrophe Sports Accident Policy.
- C. Under surgery, the maximum payment for multiple procedures performed within the same operative field shall be limited to 150% of the amount payable for the primary procedure.
- D. In the event the Insured Person sustains an injury for which benefits are payable under more than one Student Accident Insurance Policy or like coverage issued by Commercial Travelers, coverage shall be deemed to be in effect only under one such Plan, the one affording the greater (or greatest) amount of benefits for the injury.

Note: Certain of these exclusions or limitations may be modified to meet specific state requirements.

Claim forms are also available through our website: www.commercialtravelers.com

THIS IS A DESCRIPTIVE BROCHURE: NOT A POLICY—ALL PLANS ARE SUBJECT TO INSURANCE DEPARTMENT APPROVAL

NOTE: Rates reflected in this brochure were determined for the 2014 underwriting season. Please check with your agent to assure that rates have not been revised. Policy Form No. CTP-7(GWP). These plans are not available in all states.

Premium(s) quoted in this brochure cannot be refunded or pro-rated

Notes

Enrollment Request

Name of School or Center _____
 Street Address _____
 Mailing Address _____
 City _____ County _____ State _____ Zip _____
 Telephone No. (____) _____ Fax No. (____) _____
 New Client Renewal Client e-mail address _____

1. What is the Effective Date of School Term (first day of school)? ____/____/____ Last Day? ____/____/____
 2. What is the Termination Date (first day of next school year)? ____/____/____
 3. What is the Effective Date of Football Coverage (first day of practice)? ____/____/____ No. of Football Players? ____
 4. What is the Effective Date of Sports other than Football (first day of practice)? ____/____/____
 5. It is agreed and understood that (a) student insurance becomes effective on the opening day of school; (b) Football and other sports coverage becomes effective the first day of authorized practice; or (c) on the date this application or individual enrollment is received, whichever is later. Please check **one**:

PLAN 1—ALL SCHOOL PLAN **High Option** **Low Option**
Minimum Premium: \$500.00

— OR —

PLAN 2—ALL ATHLETIC PLAN **Elite Plan** **Superior Plan** **Economy Plan**
Minimum Premium: \$500.00

— OR —

PLAN 3—PRIMARY INDIVIDUAL VOLUNTARY STUDENT PLAN

6. Individual Voluntary Student Plan envelope should be
 MAIL-BACK VERSION (Returned directly to the Agent)
 SCHOOL-RETURN VERSION (Returned directly to school, school forwards to Agent)

7. STUDENT ENROLLMENT: Grades N-8 _____ Grades 9-12 _____ Total _____

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Requested by: _____
Signature of School Official Title

_____ / ____ / ____
Name of School Official—Print or Type Date

Complete and mail or fax to: **Gene Weber Agency • 1542 S. Wickham Rd. • W. Melbourne, FL 32904-3541**
FAX (321) 726-6350 • IF YOU HAVE ANY QUESTIONS CALL (321) 253-9000

FOR COMPANY USE ONLY		App. Rec'd: _____
Policy No.: _____	Forms attached: _____	Env. No.: _____
Effective Date: _____	_____	Amount Sent: _____
Expiration Date: _____	_____	Supplies Sent: _____
Sub Agent: _____	_____	Policy Sent: _____

GENE WEBBER AGENCY

1542 S. Wickham Rd.

W. Melbourne, FL 32904-3541



Important Information Enclosed