Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

SCHOOL SPONSORED STUDENT ACCIDENT INSURANCE PLAN

$25,000 Maximum Benefit

ACCIDENT COVERAGE

This plan covers medical expenses incurred from accidental bodily injuries including but not limited to: 1) broken arm from falling off bicycle, 2) concussion from being hit in the head, or 3) lacerated foot from stepping on broken glass. This plan does not cover medical expenses from sicknesses such as measles, mumps, or the flu.

CHOOSE FROM TWO PLANS OF PROTECTION FOR YOUR CHILD

A. School Time Only Protection covers most school sponsored and supervised activities including regular school session, summer school, direct travel to and from regular school sessions, direct and uninterrupted travel to and from school activities, as well as participation in most school activities.

B. 24-Hour Round-the-Clock Protection provides coverage on a 24-hour per day basis – during school hours, after school, evenings, weekends, holidays, and summer vacation - anywhere in the world through July 31, 2017.

PLEASE NOTE: Injuries from tackle football not sponsored and supervised by your child's school are not covered under this plan.

BENEFITS: are provided for accidental injuries for which medical treatment by a legally qualified physician, surgeon (other than a family member), dentist, or registered nurse, hospital service, ambulance services, of X-rays are rendered. The initial treatment must be rendered within 60 days of accident. The Usual and Customary expenses incurred for necessary medical, dental or hospital care will be paid subject to the provisions of the plan selected and the limitations and exclusions outlined in this brochure. Benefits are limited to treatment rendered within one (1) year of the date of accident. All claims must be submitted to the company within 90 days from the date of accident. This plan covers accidental bodily injuries resulting in death and dismemberment. The payable benefit amount for accidental deaths is $10,000. The payable benefit amount for accidental dismemberment is a maximum of $20,000 - the actual amount will be determined according to the dismemberment scheduled listed in the Policy. The Exposure and Disappearance Benefit included on the Policy extends coverage for the following: Exposure - If an Insured is exposed to weather because of an Accident and this results in death, the Insured will be eligible for the applicable accidental death benefit.; Disappearance - If the conveyance in which an Insured is riding disappears, is wrecked, or sinks, and the Insured is not found within 365 days of the event, it will be presumed that the person lost his or her life as a result of injury and the Insured will be eligible for the applicable accidental death benefit.

MAXIMUM

The maximum benefit payable for medical expenses as a result of any one accident is $25,000.

COVERED MEDICAL EXPENSES

Coverage under the Accident Medical Expense Benefit applies to the following Medical Services resulting from a Covered Injury.

Hospital Room and Board are covered to a maximum of $1,000 of the Usual and Customary charges.
Ancillary Hospital Expenses including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined are covered to a maximum of $2,000 of the Usual & Customary charges.

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Medical Emergency Care (room and supplies) expenses incurred within twenty-four hours of an accident are covered to a maximum of $50 of the Usual & Customary charges.
Outpatient Surgical Room (includes Ambulatory Surgical Facilities) are covered to a maximum of $500 of the Usual & Customary charges.
Outpatient diagnostic X-rays, laboratory procedures and tests are covered to a maximum of $500 of the Usual and Customary charges.
Physician non-surgical treatment/examination expenses (excluding medicines) including the physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician are covered to a maximum of $250.
Physician's surgical expenses are covered to a maximum of $1,500 of the Usual and Customary charges. If a covered injury requires multiple surgical procedures during the same operative session through the same or different incision, only one benefit will be paid, the largest of the procedures performed.
Assistant physician expenses, when medically necessary, are covered to a maximum of the Usual and Customary charges.
Registered nurse services, when medically necessary, (the nurse cannot be a member of the insured's immediate family) are covered to a maximum of $250.
Anesthesiologist expenses are covered to a maximum of 30% of Surgery expense.
Physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of five (5) visits. Expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy are covered to a maximum of $250.
Non-emergency inpatient and outpatient X-ray expenses (including reading charges) but not for dental X-rays unless Medically Necessary to evaluate a Covered Injury are covered to a maximum of $150 of the Usual and Customary charges.
Radiological procedures are covered to a maximum of the Usual and Customary charges.
Diagnostic imaging expenses including MRI and CAT Scan are covered to a maximum of $500 of the Usual and Customary charges.
Ambulance expenses for transportation from the emergency site to the Hospital are covered to a maximum of $500 of the Usual and Customary charges.
Rehabilitative limb braces, wheelchairs and other medical equipment or appliances prescribed by a Physician are covered to a maximum of $1,000 of the Usual and Customary charges.
Prescription drug expenses, for Covered Injuries, prescribed by a Physician and administered on an outpatient basis are covered to a maximum of the Usual and Customary charges.
Expenses for blood and blood transfusions; oxygen and its administration are covered to a maximum of the Usual and Customary charges.
Dental expenses, for Covered Injuries, are covered to a maximum of $2,500 of the Usual and Customary charges.
Eyeglasses, contact lenses or hearing aids damaged or destroyed as a result of a Covered Injury and prescribed by a Physician are covered to a maximum of $750 of the Usual and Customary charges.

EXCLUSIONS

GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. war or any act of war, whether declared or undeclared.
3. illness or disease; medical or surgical treatment of illness or disease or complications following the surgical treatment of illness or disease, except for **Accidental** ingestion of contaminated foods
4. participation in the commission or attempted commission of any felony.
5. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
6. being intoxicated.
   a. An **Insured** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured's** intoxication.
8. being under the influence of any narcotics unless administered on the advice of a **Physician**.
9. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
10. a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**.
11. any condition for which the **Insured** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.
12. the **Insured** riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.

ACCIDENT MEDICAL EXPENSE EXCLUSIONS

In addition to the General Exclusions stated on the policy, expenses under this additional benefit will not be covered for:

1. Fighting or brawling except in self-defense.
2. Any expense for which benefits are payable under Catastrophic Accident Insurance Program of the State High School Interscholastic Activities Association, or any state equivalent.
3. Reinjury of the same body part within 6 months of the **Covered Accident** unless previously cleared by a **Physician** to practice or play
4. Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.
5. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
6. Any expenses for a **Pre-existing Condition**.
7. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.

8. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
9. Treatment by any immediate family member or member of the **Insured's** household.
10. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury.**
11. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
12. A hernia.
13. Routine physical examinations and related medical services, or elective treatment or surgery or experimental or investigative treatments or procedures.
14. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
15. Expenses which the **Insured** is not legally obligated to pay.
16. Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.
17. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.
18. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.
19. Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.

CLAIM PROCEDURE

In the event of a claim, occurring other than during school hours, notify Bollinger by calling 866-267-0092 or print a claim form directly from our website www.BollingerSchools.com. (Note: Claims occurring during school hours fall under the school policy. For such claims you can obtain a claim form from the school.)

ID CARD

STUDENT ACCIDENT INSURANCE

Name: ____

Street Address: ________________________________

Town: __________ **City**: ________ **State**: ____ **Zip**: ______

School District: _________________________________

To obtain a claim form, please visit www.BollingerSchools.com

Administered by:

Bollinger Specialty Group

P.O. Box 1346, Morristown, NJ 07962

1-866-267-0092

Please store your card in a safe location for fututre reference.

DO NOT RETURN THE ENROLLMENT FORM TO THE SCHOOL.

Make your check or money order payable to BOLLINGER, INC.

Mail the form and the appropriate premium to:
Bollinger Specialty Group, PO Box 1515, Morristown, NJ 07962

Your cancelled check is your receipt.

VOLUNTARY STUDENT ACCIDENT INSURANCE PLAN

SCHOOL SPONSORED STUDENT ACCIDENT INSURANCE PLAN COST PER SCHOOL YEAR

SCHOOL TIME ONLY PLAN		24-HOUR 'ROUND THE CLOCK PLAN
$17.00 Coverage through the last day of school in June 2017	**OR**	**$88.00** Coverage through July 31, 2107

FOOTBALL ONLY PLAN

$128.00

Football Only Plan may be purchased separately or in conjunction with the School Time Only or 'Round The Clock Plan.

Coverage through July 31, 2017.

This is intended as a general description of certain types of insurance and services available to qualified customers through the Zurich American Insurance Company (1400 American Lane, Schaumburg, IL 60196, phone number 800-382-2150, NAIC # 16535, domiciled in New York) solely for informational purposes. Nothing herein should be construed as a solicitation, offer, advice, recommendation, or any other service with regard to any type of insurance product underwritten by Zurich American Insurance Company. Your policy is the contract that specifically and fully describes your coverage, terms and conditions. The description of the policy provisions gives a broad overview of coverages and does not revise or amend the policy.

Coverages and rates are subject to individual insured meeting our underwriting qualifications and product availability in applicable states.

Enrollment Form

Blanket Accident Insurance

ZURICH

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of **Policyholder**: (School, District, Diocese, etc.) Name of individual School enrolled in:	

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: **N/A**	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female	Marital Status: **N/A** ☐ Single ☐ Married ☐ Domestic Partner	
Email Address: **N/A**	Home Phone: **N/A**	Work Phone: **N/A**	Cell Phone: **N/A**
Requested Effective Date (MM/DD/YYYY): **N/A**			

PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):		Relationship to Enrollee: ☐ Parent ☐ Legal Guardian	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY): **N/A**	Gender: ☐ Male ☐ Female		
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

INSURANCE REQUESTED	
Benefit(s) Included:	**Coverage Amount**
Accidental Death Benefit	as per the Policy Schedule
Accidental Dismemberment Benefit	as per the Policy Schedule
Exposure and Disappearance Benefit	as per the Policy Schedule
Accident Excess Integrated Medical Expense Benefit	as per the Rider

BENEFICIARY DESIGNATION		
Primary Beneficiary:		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
Contingent Beneficiary:		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

PREMIUM INFORMATION:	
Enrollee:	$
Frequency of Payment: ☒ Annually	
Method of Payment: ☒ Agency Bill	

INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic): Date:

Parent or Legal Guardian's Signature (may be electronic): Date:

MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO: BOLLINGER INC.

MAIL THE COMPLETED APPLICATION AND PAYMENT TO:

BOLLINGER SPECIALTY GROUP

PO BOX 1515

MORRISTOWN, NJ 07962