K-12 Voluntary Student Accident Insurance

Available Coverage Options

Depending on which program your school provides, some or all of the following voluntary insurance products are available for purchase on a voluntary basis:

- $500,000 School Time Only Student Accident Insurance
- $500,000 'Round The Clock – 24 Hour Accident Coverage
- $10,000 Student Life Insurance
- $5,000 Student Dental Accident Insurance

Kids will be Kids!

1. Make sure your child is properly covered against unforeseen accidents.
2. Purchase coverage at your convenience from any computer.
3. Follow the easy step by step instructions and you're done in minutes!

These Voluntary Participation Student Accident Insurance Plans offered through your school can be purchased easily online at:

www.BollingerSchools.com

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

Bollinger Specialty Group
115 S Jefferson Rd, Bldg 200
Whippany, NJ 07981

1 800.350.8005
1 973.932.2876
www.BollingerSchools.com

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24 Hour Student Accident Insurance Plan

$500,000 Maximum Benefit

SCHOOL TIME ONLY COVERAGE

Your child's school has purchased group student accident insurance coverage for all students providing valuable protection against accidental injuries occurring school hours or during school sponsored and supervised activities.

EXTENDED PROTECTION FOR YOUR CHILD

This 24-hour option gives you the opportunity to extend your child's "school time only" coverage to a full 24 hours a day with all the same benefits and restrictions of your child's school plan. This way your child will be covered against accidents occurring anytime; evenings, weekends, holidays, - even during the active summer vacation months up to $500,000.

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. **PLEASE NOTE:** injuries from interscholastic athletic activities are not covered under this plan if your child's school has purchased an Athletic Accident Plan.

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 up to $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, We will presume 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.

BENEFITS ADDITIONAL TO OTHER COVERAGE

This 24-hour plan will reimburse your financial loss stemming from covered accidental injuries, up to the policy limits, regardless of any other coverage you may have (except for injuries covered under the school's school-time policy).

BENEFITS: are provided for accidental injuries for which medical treatment by a physician, surgeon, dentist, or registered nurse, hospital service, ambulance services, of X-rays are rendered. The initial treatment must be rendered within 90 days of accident and benefits are limited to treatment rendered within 260 weeks of the date of accident. All claims must be submitted to the company within 90 days from the date of accident.

MAXIMUM

The maximum benefit payable for medical expenses as a result of any one accident is $500,000.

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 up to 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 up to $5,000 of the Usual & Customary charges.
Medical Emergency Care (room and supplies) expenses incurred within twenty-four hours of an accident are covered up to $100 of the Usual & Customary charges.

Outpatient Surgical Room (includes Ambulatory Surgical Facilities) are covered up to $1,000 of the Usual & Customary charges.
Outpatient diagnostic X-rays, laboratory procedures and tests are covered up to $750 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 up to $250.
Physician's surgical expenses are covered up to $5,000 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, We will pay only one benefit, the largest of the procedures performed.
Assistant physician expenses, when medically necessary, are covered up to 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 up to $350.
Anesthesiologist expenses are covered up to 30% of Surgery expense.
Physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of ten (10) 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 up to $500.
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 up to $200 of the Usual and Customary charges.
Radiological procedures are covered up to the Usual and Customary charges.
Diagnostic imaging expenses including MRI and CAT Scan are covered up to $750 of the Usual and Customary charges.
Ambulance expenses for transportation from the emergency site to the Hospital are covered up to $1,000 of the Usual and Customary charges.
Rehabilitative limb braces, wheelchairs and other medical equipment or appliances prescribed by a Physician are covered up to $2,500 of the Usual and Customary charges.
Prescription drug expenses, for Covered Injuries, prescribed by a Physician and administered on an outpatient basis are covered up to the Usual and Customary charges.
Expenses for blood and blood transfusions; oxygen and its administration are covered up to the Usual and Customary charges.
Dental expenses, for Covered Injuries, are covered up to $4,000 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 up to $1,000 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. involvement in any type of active military service.
4. 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.
5. participation in the commission or attempted commission of any felony.
6. Parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. 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 narcotic, unless administered or consumed 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. participation in any team sport or any other athletic activity unless mentioned in the **Covered Activities**.
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.

AME EXCLUSIONS

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit 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

Underwritten by: ZURICH

Preferred Provider Network: CHN SOLUTIONS www.CHN.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 future 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.

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

VOLUNTARY STUDENT ACCIDENT INSURANCE PLAN

SCHOOL SPONSORED STUDENT ACCIDENT INSURANCE PLAN COST PER SCHOOL YEAR

24-HOUR 'ROUND THE CLOCK PLAN
$92.00
Coverage through the last day of summer vacation

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.) Named 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/Civil Union 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 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: ☐ Credit Card (if purchasing online) ☐ Bank Draft (if purchasing by mail) The Enrollee, or if the Enrollee is a minor, the Enrollee's Parent or Legal Guardian, must complete a separate authorization form for a Credit Card or Bank Draft payment.	

FRAUD WARNING

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 to the best of my knowledge and belief. 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 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