UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER: New Hanover County Schools

POLICY NUMBER: US1517073

POLICY EFFECTIVE DATE: July 1, 2021

POLICY EXPIRATION DATE: July 1, 2022

This Policy is issued in the state of North Carolina and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

10 DAY RIGHT TO RETURN THIS POLICY

If for any reason, you are not satisfied with this Policy, you may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this Policy will be deemed void, just as though it had never been issued.

THIS IS ACCIDENT ONLY COVERAGE.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS POLICY IS NOT RENEWABLE.

THIS POLICY/CERTIFICATE IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare, which is available from the Company.

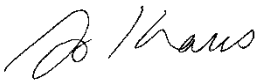
IMPORTANT CANCELLATION INFORMATION
PLEASE READ THE PROVISION ENTITLED "POLICY TERMINATION"

EXCESS INSURANCE

This Policy/Certificate is intended to be issued where medical insurance exists. If other medical insurance does not exist at the time of claim, then the amounts of benefits payable by such other medical insurance will become the deductible amount of this policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

Signed for **United States Fire Insurance Company** By:

Marc J. Adee
Chairman and CEO



James Kraus
Secretary

TABLE OF CONTENTS

The following provisions appear within this Policy in the following order:

SCHEDULE OF BENEFITS

BENEFIT PERIOD:	**52 weeks from the date of the Covered Injury, provided the Expense occurs prior to the Expiration Date and care is Medically Necessary.**
CLASS OF ELIGIBLE PERSONS:	**All registered Middle and High School Students in grades 6-12**

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum:	**$10,000**
Aggregate Limit Amount:	**$500,000**
Time Period for Loss:	**365 days**

ACCIDENT MEDICAL EXPENSE BENEFIT

Maximum Amount per occurrence per Covered Person	**$25,000**
Corridor Deductible	**$0**

Any Deductibles, Benefit Periods, and benefit maximums apply on a per Covered Person, per Covered Accident basis.

Any Deductibles apply to all of the below Accident Medical Expense Benefits unless otherwise indicated in the Schedule below.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Room & Board Daily Maximum Benefit:	**100% of the Semi-Private Room Rate up to $750**
Intensive Care/Cardiac Care Room & Board:	**100% of URC up to $750**
Hospital Miscellaneous Benefit:	**100% of URC up to $2,500**
Pre-Admission Testing Benefit:	**100% of URC up to $250**
In-Patient Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	**100% of URC up to $750**
Assistant Surgeon Benefit:	**100% of URC up to $750**

Out-Patient Surgery Benefits:

Outpatient Primary Surgeons Maximum Benefit Amount:	**100% of URC up to $750**
Outpatient Assistant Surgeon Maximum Benefit:	**100% of URC up to $750**
Outpatient Surgical Facility Maximum Benefit per	**100% of URC up to $750**
Emergency Room Benefit	**100% of URC up to $750**
Anesthesia Benefit:	**100% of URC up to $750**
Physician's Visits	
In-Hospital Maximum Benefit:	**100% of URC up to $250**
Physician's Visits	
Office Visits (Out-of-Hospital) Maximum Benefit:	**100% of URC up to $250**
X-Ray Benefit	**100% of URC up to $250**
Laboratory Benefit	**100% of URC up to $250**
Nursing Benefit Amount:	**75% of URC**
Outpatient Physiotherapy Benefit	**100% of URC up to $250**
Ambulance Benefit Amount:	**100% of URC up to $250**
Dental Treatment For Injury Only Benefit Amount:	**100% of URC up to $500**

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any Accidental Death and Dismemberment benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

The total of all benefits payable under this Policy, including all Additional Accident Benefits paid for all Injuries caused by the same Covered Accident shall not exceed the Principal Sum indicated in the *Schedule of Benefits* unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

HEART OR CIRCULATORY MALFUNCTION BENEFIT	**100% of URC up to $250**
RE-AGGRAVATION OF PRIOR SPORTS INJURY BENEFIT	**100% of URC up to $250**
OUT-PATIENT PRESCRIPTION DRUG BENEFIT	
Benefit payable per prescription	**100% of URC up to $250**

DURABLE MEDICAL EQUIPMENT BENEFIT	**$250**
Replacement of Eyeglasses, Contacts, or Hearing Aid due to a covered injury	**$10,000**

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Accident means a sudden, unforeseeable external event which:
1. Causes Injury to one or more Covered Persons; and
2. Occurs while coverage is in effect for the Covered Person.

Benefit Period means the period of time from the date of Injury, as shown in the Schedule of Benefits.

Club means an organization of students formed for the purpose of engaging in competition in a particular sport or activity. Competition between student clubs from different colleges, not organized by and therefore not representing the institution or their faculties, may also be called “Intercollegiate” sports or activities.

Corridor Deductible means the dollar amount of the Covered Expenses the Insured person must pay towards the policy before We pay any benefits regardless of what any other Insurance Plan or other Insurance Carrier has paid. It applies separately for each Covered Person.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual, Reasonable and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and Certificate and which is performed or given under the direction of a Physician for treatment of an Injury. Coverage under the Policy and Certificate must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for an Injury cannot be in excess of the maximum benefit amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Person means a person eligible for coverage as identified in the Application for whom proper premium payment has been made, and who is therefore insured under this Policy.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Policy is in force.

He, his, and him includes she, her and hers.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:
1. Group or blanket insurance, whether on an insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. Group labor management plans;
5. Employee benefit organization plan;
6. Professional association plans on a group basis; or

7. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Hospital means an institution which:
1. Is operated pursuant to law;
2. Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
3. Is under the supervision of a staff of Physicians;
4. Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
5. Has medical, diagnostic and treatment facilities;
    a. On its premises; or
    b. Available to it on a prearranged basis; and
6. Charges for its services.
7. Is a duly licensed Rehabilitation Facility
8. Includes state tax-supported institutions.

Hospital does not include:
1. A clinic or facility for:
    a. Convalescent, custodial, educational or nursing care;
    b. The aged, drug addicts or alcoholics;
2. A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. The services are rendered on an emergency basis; and
    b. A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Interscholastic means a sport or activity organized between schools or representatives of the schools.

Intramural means a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from “within the walls” of an institution or area.

Medically Necessary or Medical Necessity means a treatment, service or supply that is:
1. Required to treat an Injury; and
2. Prescribed or ordered by a Physician or furnished by a Hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy or this Certificate.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of alternative to be the Covered Expense.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether Insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Services or supplies for treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act, only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
5. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he or she becomes disabled while Insured hereunder.
6. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Physician means a person who is a qualified practitioner of medicine. A such, He or She must be acting within the scope of his/her license and under the laws in the state in which He or She practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, a Covered Person's Spouse, son, daughter, father, mother, brother, or sister or other relative.

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

School means the participating School or School District where the Covered Person is enrolled or employed. The School must be a duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate School.

Supervised or Sponsored Activity means a Policyholder or School authorized function:
1. In which the Covered Person participates;
2. Which is organized by or under its auspices;

which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

Usual, Reasonable and Customary means:
1. With respect to fees or charges, fees for medical services or supplies which are;
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

Waiting Period means the length of time from the date of loss to the time when benefits can be received.

ELIGIBILITY FOR INSURANCE

Eligibility:
Persons eligible to be insured under this Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while this Policy is in force.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date: The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date: A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:
1. The Effective Date of the Policy; or
2. The day He becomes eligible, according to the referenced date shown in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date
Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:
1. The Policy Termination Date shown in the Policy; or
2. The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 45 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination:
Insurance for a Covered Person will end on the earliest of:
1. The date he is no longer in an Eligible Class.
2. The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of this Policy.
    This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated.

Covered Person's Termination Date

Insurance for a Covered Person will end on the earliest of:

1. The date He is no longer in an Eligible Class.
2. The date He reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. The date the premium is fully earned; or
    b. The Expiration Date of this Policy.
    This does not include Reserve or National Guard duty for training;
3. The end of the period for which the last premium contribution is made; or
4. The date this Policy is terminated; or
5. The date the Covered Person requests, in writing, that his/her coverage be terminated.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which:

1. Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and results, directly and independently of disease or bodily infirmity, from an Injury which is suffered in an Accident;
2. Occurs while the person is a Covered Person under this Policy; and
3. Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Full Excess Medical Expense:

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:

1. While the person is insured under this Policy; or
2. During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Policy is shown on the SCHEDULE OF BENEFITS: and

1. Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
2. Subject to compliance with the requirement, set forth in the Limitations section of this Policy.

Non-Duplication of Benefits Provision:

This provision applies if a Covered Person:

1. Is covered by any other blanket or group health care plan; and
2. Would, as a result, receive total medical expense or service benefits in excess of the expenses actually incurred.

In this case, the medical expense benefits we will pay under this Policy will be reduced by such excess. This provision does not apply if we would be primary under any coordination of benefit guidelines contained in the other health care plans.

DESCRIPTION OF HAZARDS

HAZARD: SPORTS COVERAGE

Subject to all other provisions of this Policy, coverage is provided for a Covered Person while he is:

1. Taking part in:
    a. A regularly scheduled athletic game or competition; or
    b. A practice session for an athletic team or club;
2. Traveling to or from such a game, competition or practice session provided he is:
    a. Traveling with the athletic team or club; and
    b. Under the direct and immediate supervision of:
        i. The athletic team or club; or
        ii. An adult authorized by the athletic team or club; or
3. Traveling directly, without interruption
    a. Between his home and a scheduled game, competition or practice session;
    b. In a vehicle which is
        i. Designated or furnished by the athletic team or club;
        ii. Operated by a properly licensed, adult driver; or
        iii. Under the direct supervision of the athletic team or club; or
    c. In a vehicle other than that described in 3.b. when:
        i. Operated by a properly licensed driver; and
        ii. Travel time does not exceed 1 hour each way.

Travel time includes the time:

i. To or from home, a scheduled game, competition or practice session;
ii. Before required attendance time;
iii. After the Covered Person is dismissed; and

Injuries which result over a period (such as blisters, tennis elbow, etc.), and which are a normal, foreseeable result of the sport, are not covered.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH DISMEMBERMENTOR LOSS OF SIGHT

If, within 1 year from the date of an Accident covered by this Policy, Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Loss	**Percentage of Principal Sum**
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%

Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL and DENTAL EXPENSE BENEFITS

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Benefit Periods, benefit maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:
1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
3. for Eligible Expenses incurred within 90 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Eligible Medical Expenses, from a Covered Accident, include:

1. **Hospital room and board expenses**: charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

2. **Intensive Care Room and Board** - charges for each day of Intensive Care/ Unit confinement, up to the maximum benefit amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

3. **Hospital Miscellaneous** – services, supplies and charges during a Hospital Stay, up to the maximum benefit amount shown in the Schedule of Benefits for the Hospital Miscellaneous Benefit. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

4. **Pre-Admission Testing Benefit** – charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing)

5. **In-Patient Surgical Benefits** - charges for:

a. A Physician, for primary performance of a surgical procedure, up to the maximum benefit amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

b. A Physician, for: assistant surgeon duties up to the maximum benefit shown in the Schedule of Benefits for an Assistant Surgeon

6. **Out-Patient Surgery Benefits:**

We will pay this benefit when the Covered Person requires Outpatient Surgery to treat a Covered Loss resulting directly and independently from all other causes from a Covered Accident. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Outpatient Surgery means the treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other surgical procedure, including the usual aftercare for such procedure, that is:

a. necessary for treatment of the Covered Person; and
b. given in the outpatient department of a Hospital or an ambulatory surgical center.

7. **Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.
Emergency Room treatment includes all hospital related services including physician, x-ray and lab services shown in the Schedule of Benefits.

8. **Anesthesia Benefit** – Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis, up to the maximum benefit amount shown in the Schedule of Benefits for the Anesthesia benefit.

9. **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:

a. For in-Hospital visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

b. For office visits, up to the maximum benefit amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

10. **X-Ray Benefit -** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires x -ray examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

11. **Laboratory Benefit-** We will pay the benefit shown in the Schedule of Benefits if the Covered Person requires laboratory examinations due to a Covered Loss, up to the maximum benefit per Covered Accident indicated in the Schedule of Benefits.

12. **Nursing Benefit**– Outpatient Charges for nursing services by a registered nurse or licensed professional nurse, up to the maximum benefit amount shown on the Schedule of Benefits for the Nursing benefit.

13. **Physiotherapy -** Charges for physiotherapy:
    a. As an outpatient, up to the maximum benefit amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

    Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microthermal, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

    Total treatment per Injury will not exceed the maximum benefit amounts for Physiotherapy shown in the Schedule of Benefits*.*

14. **Ambulance** - for services billed by a professional ambulance company up to the Maximum Benefit Amount shown in Schedule of Benefits for the Ambulance benefit.

15. **Dental Treatment for Injury Only** - Charges for dental treatment including dental x-rays for the repair and treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the maximum benefit amount shown in the Schedule of Benefits for the Dental Treatment benefit.

ADDITIONAL ACCIDENT BENEFITS

HEART OR CIRCULATORY MALFUNCTION BENEFIT

We will pay benefits for a Covered Person who suffers a sudden Heart or Circulatory Malfunction that results directly and independently of all other causes, from a Covered Accident and the first symptoms of the malfunction are medically diagnosed while the Covered Person is covered under this Policy
Benefits will not be payable if in the past year, the Covered Person was medically diagnosed as having, or received treatment for:
1. a heart or circulatory malfunction; or
2. hypertension, angina or other heart or circulatory condition.

Benefits will not be payable if the Covered Person is diagnosed with a newly diagnosed congenital disorder.

Symptoms, such as shortness of breath, heart pain or numbness of a limb are covered during the first 48 hours . These symptoms are not covered beyond the first 48 hours unless:

1. they first occurred within 48 hours; and
2. an actual malfunction of the heart or circulatory system is subsequently diagnosed.

RE-AGGRAVATION OF PRIOR SPORTS INJURY
During play or practice of intercollegiate sports, benefits are payable for re-aggravation of a sports Injury suffered prior to the Effective Date of a **covered person's** coverage under the Policy. For the purposes of this Re-aggravation of Prior Sports Injury benefit only, such re-aggravation will be considered an **Injury**

if the re-injury occurs under circumstances which would have otherwise been covered under the Policy. Any exclusion for congenital conditions, sickness, or disease remains in force.

The maximum amount payable under this Re-aggravation of Prior Sports Injury benefit is limited to the amount shown on the Schedule of Benefits. This amount is included in the Aggregate Maximum Benefit Amount, per **covered person**, per accidental **injury,** as shown on the Schedule of Benefits, and is not in addition to that amount.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses- shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:
1. Under Federal law may only be dispensed by written prescription; and
2. Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:
1. On or after the Covered Person's Effective Date; and
2. By a licensed pharmacy provider.

Benefits are payable up to the maximum benefit amount shown on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT BENEFIT

We will pay the benefit shown in the Schedule of Benefits if, by reason of Injury, a Covered Person requires the use of Durable Medical Equipment.

Durable Medical Equipment means medical equipment that:
1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. can withstand long-term repeated use without replacement;
3. is not useful in the absence of the Covered Injury and
4. can be used in the home without medical supervision; and
5. the purpose of the equipment is not to help the Covered Person participate in sports activity.

Replacement of Eyeglasses, Contacts, or Hearing Aid Benefits

We will pay the benefit amount shown in the Schedule of Benefits for the replacement of Eyeglass, Contacts or Hearing Aids that are damaged as a result of a Covered Injury payable under this policy.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared that does not include terrorism.

3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Active participation in a riot or insurrection.
6. Any Injury requiring treatment which arises out of, or in the course of intentionally fighting, brawling, assault or battery.
7. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or nervous disorders.
10. Asphyxiation from voluntarily inhaling gas and not the result of the Covered Person's job.
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
12. Intoxication or being under the influence of any drug or narcotic.
13. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
15. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
16. Violation or in violation or attempt to violate any duly enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
17. Conditions that are not caused by a Covered Accident.
18. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
19. Any treatment, service or supply not specifically covered by this Policy.
20. Loss resulting from participation in any activity not specifically covered by this Policy.
21. Charges which Are in excess of Usual, Reasonable and Customary charges.
22. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
23. Regular health check ups.
24. Services or treatment rendered by a Physician, Nurse, or any other person who is employed or retained by the Policyholder.
25. Services or treatment rendered by an Immediate Family member of the Covered Person;
26. Injuries paid under Workers' Compensation, Employers liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
27. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.
28. Travel or activity outside the United States.
29. Participation in any motorized race or speed contest.
30. Aggravation or re-injury of a prior injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
31. Heart attack, stroke or other circulatory disease or disorder, whether known or diagnosed, unless the immediate cause of Loss is external trauma.
32. Treatment of a hernia whether caused by a Covered Accident.
33. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
34. Damage or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.

35. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy and rendered within 6 months of the Accident..
36. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
37. Travel in or upon:
a. A snowmobile;
b. A water jet ski;
c. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
d. Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for recreation competition.
38. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
b. While being used for any test or experimental purpose; or
c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
f. an ultralight hang-gliding, parachuting, or bungee-cord jumping
Except as a fare paying passenger on a regularly scheduled commercial airline .
39. Practice or play in any amateur, intercollegiate, school activity or professional sports contest or competition.
40. The repair or replacement of existing artificial limbs, orthopedic braces or orthotic devises.
41. Rest cures or custodial care.
42. Prescription medicines unless specifically provided for under this Policy.
43. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
44. Massage Therapy. Physical Therapy or Acupuncture/Acupressure Services, unless otherwise specifically allowed for in the Schedule of Benefits.
45. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

LIMITATIONS

Any benefits payable under this Policy will be limited to the following:

(1) The medical benefits otherwise payable under this Policy will be reduced by 50% if:
(a) Excess insurance is provided under this Policy; and
(b) The Covered Person has coverage under another plan providing medical expense benefits; and
(c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and
(d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) In the event no consenting surgical opinion is obtained for those procedures that mandate such second surgical opinion benefits payable for all Eligible Expenses associated with the procedure will be reduced by 50%. This limitation will apply whether the surgery is performed on an in-patient or out-patient basis. We will not cover a second opinion given more than 6 months after surgery was first recommended.

(3) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished, or supplies provided. Services, supplies and equipment must be:
   (a) Medically necessary for the care or treatment of a covered Injury;
   (b) Received while coverage is in force under this Certificate; and
   (c) Rendered and/or prescribed by a licensed Physician other than the Covered Person (or a member of his household or immediate family) in accordance with current medical standards and practices.

(4) The application of the Non-Duplication of Benefits provision.

(5) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital cages for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

AGGREGATE LIMIT

The Aggregate Limit Amount is shown on the Schedule of Benefits. We will NOT be liable for any amount over such limit for any one Accident.

If the total amount of benefits to be paid under this Policy is more than the Aggregate Limit Amount, the benefit amount payable for a Covered Person's loss will be determined as a proportionate share of the Aggregate Limit Amount.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the grace period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one-month period will not affect any provisions of this Policy with regard to change. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
1. After the first 12 months insurance is in effect;
2. Coinciding with a change in the coverage provided or classes eligible; or
3. Coinciding with a change in the risks we have assumed.

We will give 45 days written notice of any change under 1. above. Notice will be sent to the Policyholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Policy, the application of the Policyholder (if any, a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Covered Person's effective date of coverage, no misstatements will cause such coverage to be void or cause the denial of a claim for loss incurred or disability commencing after the expiration of such two-year period.
No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:
This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office as shown on the cover page or to our agent. Notice should include the Policyholder's name and number and a Covered Person's name and address.

CLAIM FORMS:
When we receive the notice of claim, we will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 180 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 180 days after the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. The beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or children;
4. Mother or father;
5. Sisters or brothers; or
6. The estate of a Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Covered Person's death may, at our option, be paid either to his beneficiary or to his estate. All other benefits, unless specifically stated otherwise, will be paid to a Covered Person.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at our expense unless prohibited by law.

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT APPLICATION

1. POLICYHOLDER INFORMATION

Applicant/Policyholder (Full Legal Name): New Hanover County Schools

Address: 6410 Carolina Beach Road

City: Wilmington State: NC Zip Code: 28412

Phone Number: 910-254-4200 Fax Number: _____

Type of business or organization: Schools

Covered Activities: Middle and High School Sports

Duration of Covered Activities: 07/01/21 - 07/01/22

2. Requested Effective Date: 07/01/2021

3. Class of Eligible Persons: All registered Middle and High School Athletes in grades 6-12

4. Description of Benefits (See attached Schedule of Benefits):

Persons who qualify within the Plans and classes described below are eligible to be insured under the Policy.

The Applicant/Policyholder agrees to the following terms.

1. The Applicant will promptly furnish any records or other information necessary to insure the proper administration of the insurance plans to the Underwriting Company. The Applicant further agrees to allow the Underwriting Company or its Administrator to examine all records that pertain to the insurance plans.
2. The consideration for the requested insurance is the Underwriting Company's acceptance of this application and the Applicant's payment of the required premium when due. Payment of the required premium, if any, after delivery of the policy acts as acceptance of the terms and conditions of the policy.

The Applicant represents that the information provided to the Underwriting Company to determine the terms of the insurance applied for is true and correct and forms the basis of the requested insurance.

IMPORTANT NOTE: 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.

ACCEPTANCE:

[signature] Chief Finance Officer Date: 5/5/21

(Signature of Applicant's Authorized Representative) (Title of Applicant's Authorized Representative)

Wilmington, NC

(City and State)

Accepted by: _____ _____ Date: _____

(Signature of Underwriting Insurance Company Representative) (Title of Underwriting Insurance Company Representative)

FOR COMPANY USE ONLY:

SALES OFFICE: _____ **BROKER/AGENT:** _____

UNITED STATES FIRE INSURANCE COMPANY
Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

North Carolina Fiduciary Notice

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Crum & Forster A&H Division
5 Christopher Way, 2nd Floor
Eatontown, New Jersey 07724

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance

contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

When used throughout this document "Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:
(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:
(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;

(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA WARNING: 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY:

Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Claim Form: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

NEW YORK*: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature _____ Date _____

*The fraud warning in NY must appear above the signature line.

SPORTS INSURANCE SPECIALISTS

K-12 STUDENT
ACCIDENT CLAIM FORM

Please complete and submit to A-G Administrators with itemized medical bills AND primary insurance explanation of benefits.

All forms and documents should be submitted to claims@agadm.com for prompt upload to the claim file.

For questions, however, please contact A-G Administrators: customerservice@agadm.com.

YOUR INFORMATION

First Name:_____ Last Name:_____

Title:_____ School/Organization Name:_____

Email Address:_____ Phone Number:_____

POLICYHOLDER INFORMATION

Policyholder (School):_____

School Address:_____
STREET CITY STATE, ZIP

STUDENT INFORMATION

Student's Name:_____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth:_____ Sex: ☐ M ☐ F **Social Security #:**_____

Student's Phone Number (or Parent's if minor): _____

Student's EMAIL (or Parent's if minor): _____

Student's Home Address: _____
STREET CITY STATE, ZIP

ACCIDENT INFORMATION

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other (Please explain in Nature of Injury section.)

Type of Activity: ☐ Club Sport ☐ Intramural ☐ Interscholastic ☐ Non-Athletic

Activity/Sport (if athletic related):_____ Accident Date:_____

Body Part Injured:_____ Place of Accident:_____

Nature of Injury (Details of what happened.):_____

_____

_____

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No (Attach separate documents if necessary.)

Insurance Company Name:_____

Insurance Company Address:_____
STREET CITY STATE, ZIP

Policy Number: _____ ID#:_____

A-G ADMINISTRATORS LLC
SPORTS INSURANCE SPECIALISTS
PO Box 21013, Eagan, MN 55121
Ph: **(610) 933-0800** *Fx:* **(610) 933-4122** *Email:* **claims@agadm.com**

AUTHORIZATION

AFFIDAVIT: I verify the statement regarding other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization, or any family member to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees. I also authorize A-G Administrators to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

STUDENT/PARENT APPROVAL: I certify that approval has been granted from the student or student's parent or legal guardian (if minor) to submit this claim.

AUTHORIZED POLICYHOLDER SIGNATURE *(Parent or guardian, if participant is a minor)*	**DATE**

Notice to CALIFORNIA RESIDENTS: The California Consumer Privacy Act (CCPA) is a comprehensive privacy law that went into effect on January 1, 2020. The CCPA provides enhanced rights to California residents, including a right to access information, a right to delete information (in certain circumstances), and a right to opt out of the sale of information. Please direct any inquiries regarding the CCPA to your third party administrator claim representative.

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

Alabama: presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR and RI: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: 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.

Florida: 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 of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky: and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New York: and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Louisiana: 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.

New Mexico: 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 civil fines and criminal penalties.

Texas: presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

West Virginia: 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.

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

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

A-G ADMINISTRATORS LLC
SPORTS INSURANCE SPECIALISTS
PO Box 21013, Eagan, MN 55121
Ph: **(610) 933-0800** *Fx:* **(610) 933-4122** *Email:* **claims@agadm.com**