

# **West Muskingum Schools**

Administration Center, 4880 West Pike, Zanesville, OH 43701  
Phone: 740-455-4052/FAX 740-455-4063/westmschools.org

*Home of the Tornadoes*

**Chad J. Shawger**  
Superintendent

**Kimberly S. Downs**  
Treasurer

Dear Parents:

Our school district has made arrangements with Student Protective Agency to provide student accident insurance for those wishing to purchase coverage this year. Please note the coverage shown on the application. Covered losses less than \$250 are paid without regard to other insurance.

High school football coverage requires an additional premium. All other school supervised sports are covered under the plan. On claims over \$250 this is an excess coverage policy for which benefits are payable only for that part of the loss not covered by other collectible insurance. If a person has no other insurance, the Company will pay the covered medical expenses incurred within one year, up to the specified limits of the policy.

Please note that the student applications will be available on our website. Complete the application and check the boxes for coverage desired. Tear off and keep the rest of the application, as it shows not only the coverage but the exclusions and limitations of the policy.

Mail the applications directly to Student Protective Agency, 300 Coshocton Avenue, Mount Vernon, OH 43050 along with a money order or check payable to Student Protective Agency. The school will be notified as to who takes out coverage. You can call Student Protective Agency at 800-278-2544 for more information.

In case of an accident the student or parent should immediately go to the building principal who will sign and provide the claim form if only school time coverage is taken out. 24 hour coverage needs no signature. The policy number shall be provided by the school for the claim or you can call 800-278-2544. You may give that policy number to the doctor or hospital but the bills should be sent to the parent or guardian who attach them to the claim form. Once completed, mail to the claims office at Guarantee Trust Life Insurance, PO Box 1148, Glenview, IL 60025. If you have any further questions regarding a claim, please call 1-800-622-1993. It is the responsibility of the parent or guardian to file the claim.

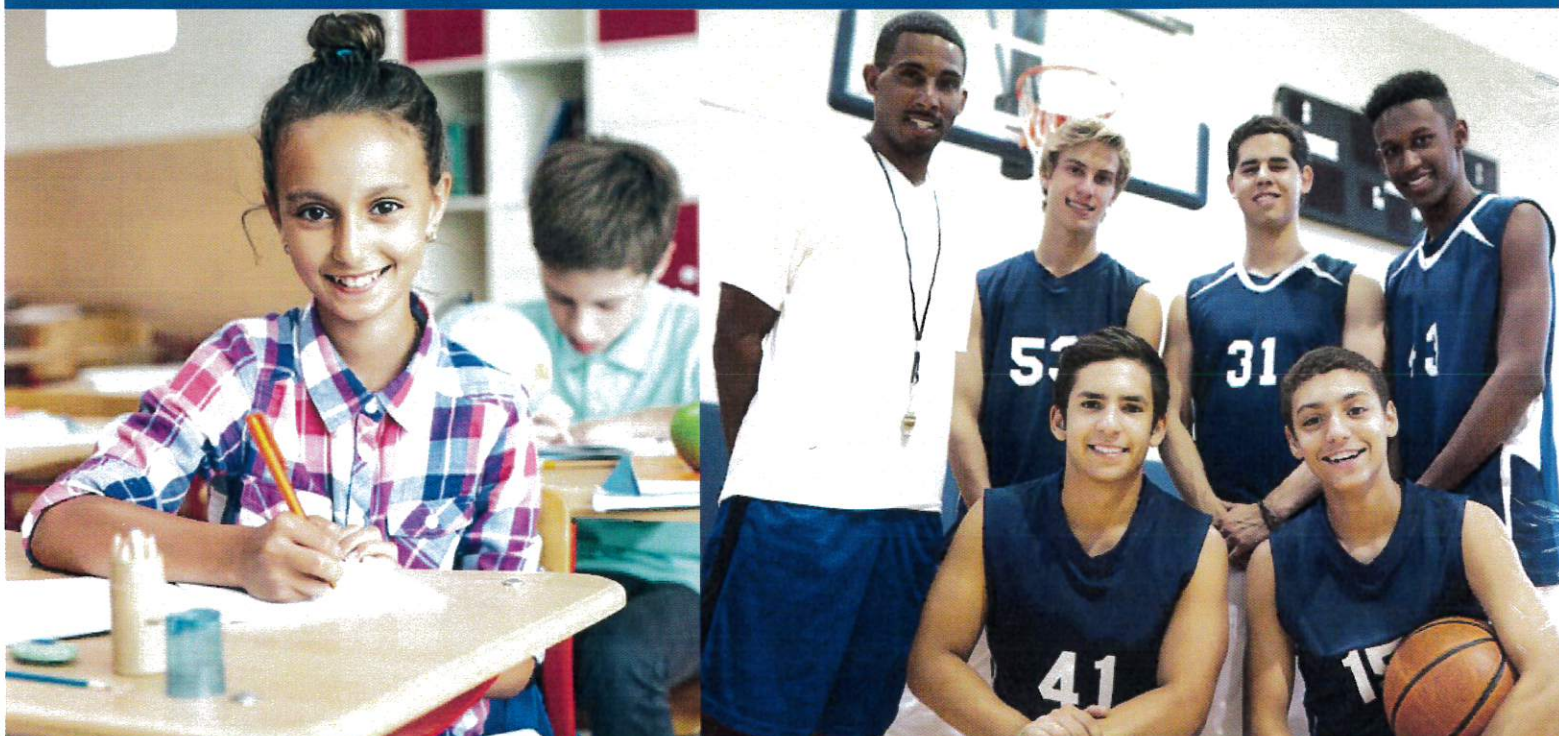
Kimberly Downs  
Treasurer

# 2022-23 OHIO STUDENT ACCIDENT INSURANCE PROGRAM Multi-Benefit Protection

*Plan Administered by:*

**Student  
Protective  
Agency**

300 Coshocton Ave.  
Mount Vernon, OH 43050  
1-800-278-2544



## ***ACCIDENT INSURANCE PROTECTION HELPING PROVIDE:***

**For the Student** - Sound coverage with a selection of plan options

**For the Parent** - Additional financial security to help in times of increasing medical costs

**For You** - The fulfillment of an administrative service and responsibility

*Underwritten & Claims Administered by:*

**GTL** | GUARANTEE  
TRUST  
LIFE

Guarantee Trust Life Insurance Company (GTL)  
1275 Milwaukee Ave., Glenview, IL 60025  
1-800-622-1993  
[www.gtlic.com](http://www.gtlic.com)





## ACCIDENT INSURANCE PLANS

for all students and athletes

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**SCHOOL-TIME STUDENT ACCIDENT COVERAGE:** Helps protect your students the entire school year, during regular school sessions, as well as participating in other school-sponsored activities requiring the attendance of the student. Also provides protection for your students while traveling directly to or from the student's Residence and school to attend or participate in school activities. The expiration date of coverage shall be the close of the regular nine month school term, except while the Insured is attending academic classroom sessions exclusively sponsored and solely supervised by the school during the summer.

**24-HOUR-A-DAY ACCIDENT COVERAGE:** Provides protection for your students 24-hours-a-day, year-round and continues until the end of the Policy Year. The student is protected AT HOME, AT SCHOOL, AT CAMP, ON VACATION. . . ANYWHERE ACCIDENTS CAN HAPPEN.

**SPORTS ACCIDENT COVERAGE:** Interscholastic sports (including practice) are covered by the School-Time and 24-Hour-A-Day Accident Coverage. Travel is also covered when going directly and uninterruptedly to and from practice or competition when traveling as a group in a Designated Vehicle. High school tackle football for grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) is only covered by the optional Football Only Accident Coverage, which requires an additional premium.

**FOOTBALL ONLY ACCIDENT COVERAGE:** Players in Grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) are covered for accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is also covered when going directly and uninterruptedly to and from such practice or competition when traveling as a group in a Designated Vehicle.

**EFFECTIVE COVERAGE DATES:** Coverage will be effective on the date of premium receipt by GTL, its representatives or school officials, or the official first day of school, whichever is later.

For interscholastic sports, coverage can pre-date the official first day of school for students who are participating in pre-school practice sessions, competition or covered travel sanctioned by the Ohio High School Athletic Association. In such cases coverage will be effective as of the date of premium receipt but only while participating in actual practice sessions, competitions or covered travel. Other aspects of coverage will not commence until the official first day of school.

Football Only Accident Coverage begins on the date of premium receipt by GTL, its representatives or school officials, but not prior to the first official date of practice and no earlier than August 1st as sanctioned by the Ohio High School Athletic Association and continues through the date of the last official game of the 2022 season, including playoffs. Other aspects of coverage will not commence until the official first day of school.

**EXCESS PROVISION:** All Covered Charges will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance covers the Insured person.

## 2022-23 POLICY BENEFITS AND PREMIUMS

**All Maximum amounts are per Injury except as specifically stated.**

Injury means bodily injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Covered Person's coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries are considered a single Injury.

COVERAGE AND BENEFITS	LOW OPTION	HIGH OPTION
Maximum Benefit Amount Per Injury	\$25,000.00	\$25,000.00
Deductible	\$0.00	\$0.00
Hospital Room and Board and general nursing care limited to a maximum of	\$150.00/day	\$300.00/day
Hospital Miscellaneous Expense limited to a maximum of	\$1,000.00	\$2,000.00
Hospital Emergency Care limited to a maximum of	\$150.00	\$300.00
Orthopedic Appliances furnished by the Hospital limited to a maximum of	\$100.00	\$200.00
Doctor's fees for surgery, in accordance with the Surgical Schedule using	\$80.00 per unit value	\$160.00 per unit value
Anesthesia Services, limited to	25% of the Surgical Schedule allowance	25% of the Surgical Schedule allowance
Non-Surgical Doctors' Visits, including Physical Therapy Physical Therapy is limited to a maximum benefit of 3 visits.	\$25.00	\$50.00
Dental Treatment, per tooth (for Injury to Sound, Natural Teeth) limited to Up to a maximum of	\$200.00 \$600.00	\$400.00 \$1,200.00
Imaging procedures, including X-rays and interpretation, limited to a maximum of amount of	\$100.00	\$200.00
MRI/CAT Scan, up to a maximum benefit of	\$125.00	\$250.00
Ambulance Expense, limited to a maximum of	\$100.00	\$200.00
Loss of Life	\$2,000.00	\$2,000.00
Loss of One Hand or One Foot or Entire Sight of Both Eyes	\$1,000.00	\$1,000.00
Loss of both Hands or Feet	\$10,000.00	\$10,000.00
PREMIUMS (ONE-TIME PAYMENT)	LOW OPTION	HIGH OPTION
<b>SCHOOL-TIME ACCIDENT COVERAGE</b>		
Students — Grades K - 6	\$23.00	\$46.00
Grades 7 - 12	\$37.00	\$74.00
<b>24-HOUR-A-DAY ACCIDENT COVERAGE</b>		
Students — Grades K - 6	\$79.00	\$158.00
Grades 7 - 12	\$91.00	\$182.00
<b>OPTIONAL FOOTBALL ONLY ACCIDENT COVERAGE</b>		
Per Player — Grades 10 - 12 (including grade 9 if playing or practicing with grades 10 through 12)	\$129.00	\$258.00



## EXCLUSIONS

**THE POLICY DOES NOT COVER:** (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy; (2) Intentionally self-inflicted Injury; (3) Injury sustained while violating or attempting to violate any duly enacted law; (4) Injury by acts of war, whether declared or not; (5) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four-wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained while participating in or practicing for senior high interscholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

## IMPORTANT INFORMATION

1. Treatment must begin within thirty (30) days of Accident.
2. Expense must be incurred within fifty-two (52) weeks of Accident.
3. Written proof of loss must be furnished within ninety (90) days of Accident.
4. No refunds are available.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL), its representatives or school officials (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

**Optional Football Only Accident Coverage** begins on the date of premium receipt by GTL, its representatives or school officials, but not prior to the first official date of practice; and continues through the date of the last official game of the current season including playoffs.

**Football premium covers football only.**

**To file a claim:** Report accidents to the school. Forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Complete proof of loss and accumulated bills must be received by Guarantee Trust Life Insurance Company within 90 days.

## 24-HOUR-A-DAY ACCIDENT COVERAGE

### *24-Hour-A-Day Protection for each Covered Accident*

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

- 📁 At home    📁 At play    📁 At school    📁 On vacation    📁 Scouting, camping etc.    📁 During covered travel
- 📁 While engaged in sports, except those specifically excluded or for which optional coverage is required\*

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

## SCHOOL-TIME ACCIDENT COVERAGE

Helps protect your child while attending regular school sessions. Includes coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See **OPTIONS** for available optional sports coverage, if any.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

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

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS FROM ACCIDENTAL BODILY INJURY RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES
- COVERED MEDICAL EXPENSE WHICH BEGINS WITHIN 30 DAYS OF THE ACCIDENT AND IS INCURRED WITHIN 52 WEEKS OF THE ACCIDENT

## COVERAGE AND BENEFITS

BENEFITS ARE PAYABLE UP TO THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		LOW OPTION	HIGH OPTION	BENEFITS PER INJURY		LOW OPTION	HIGH OPTION
HOSPITAL ROOM AND BOARD AND GENERAL NURSING CARE	Per day	\$150	\$300	IMAGING PROCEDURES	Including X-rays and interpretation	\$100	\$200
HOSPITAL MISCELLANEOUS EXPENSE		\$1,000	\$2,000	MRI/CAT Scan		\$125	\$250
HOSPITAL EMERGENCY CARE		\$150	\$300	ORTHOPEDIC APPLIANCES	Furnished by the Hospital	\$100	\$200
DOCTOR'S FEES FOR SURGERY	Per Unit Unit Value determined by the Surgical Schedule	\$80	\$160	DENTAL TREATMENT	For Injury to Sound, Natural Teeth, per tooth Up to a maximum of	\$200 \$600	\$400 \$1,200
ANESTHESIA SERVICES	Percent of Surgical Schedule Allowance	25%	25%	ACCIDENTAL DEATH AND DISMEMBERMENT  Only one of these benefits, the largest, will be payable in addition to other benefits shown	Caused by an Injury and occurring within 365 days of the covered Accident	<b>ACCIDENTAL DEATH</b> \$2,000  <b>DISMEMBERMENT</b> Loss of One Hand or One foot \$1,000 Loss of the Entire Sight of Both Eyes \$1,000 Loss of Both Hands or Feet \$10,000	
AMBULANCE EXPENSE		\$100	\$200				
DOCTORS' VISITS Non-surgical Including Physical Therapy	Per visit	\$25	\$50				
	Physical Therapy, per visit	\$25	\$50				
	Maximum number of visits per Injury	3	3				

Injury means bodily Injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Insured's coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

### EXCLUSIONS

THE POLICY DOES NOT COVER: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy; (2) Intentionally self-inflicted Injury; (3) Injury sustained while violating or attempting to violate any duly enacted law; (4) Injury by acts of war, whether declared or not; (5) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four- wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained while participating in or practicing for senior high inter-scholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

Administered by: **STUDENT PROTECTIVE AGENCY**, 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

Underwritten and claims paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**, 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

# 2022-2023 SCHOOL YEAR ENROLLMENT FORM

**GTL** | GUARANTEE  
TRUST  
LIFE

PLEASE PRINT CLEARLY

ONE TIME ANNUAL PAYMENT		
OPTIONS	LOW OPTION	HIGH OPTION
<b>24-HOUR-A-DAY PLAN</b> STUDENTS GRADES K-6 STUDENTS GRADES 7-12	<input type="checkbox"/> \$79 <input type="checkbox"/> \$91	<input type="checkbox"/> \$158 <input type="checkbox"/> \$182
<b>SCHOOL-TIME PLAN</b> STUDENTS GRADES K-6 STUDENTS GRADES 7-12	<input type="checkbox"/> \$23 <input type="checkbox"/> \$37	<input type="checkbox"/> \$46 <input type="checkbox"/> \$74
<b>OPTIONAL FOOTBALL COVERAGE</b> (GRADES 10-12, INCLUDING GRADE 9 IF PLAYING WITH 10-12) 2022 SEASON ONLY PER PLAYER	<input type="checkbox"/> \$129	<input type="checkbox"/> \$258
<b>TOTAL \$</b> _____ (PLEASE DO NOT SEND CASH)		
<b>MAKE CHECK PAYABLE TO YOUR LOCAL AGENCY</b>		
<b>NO REFUNDS ARE AVAILABLE</b>		

<b>STUDENT'S NAME</b> _____ FIRST NAME MIDDLE INITIAL LAST NAME		
<b>DATE OF BIRTH</b> _____ MONTH DAY YEAR		<b>MALE</b> <input type="checkbox"/> <b>FEMALE</b> <input type="checkbox"/>
<b>SCHOOL DISTRICT</b> _____		<b>SCHOOL</b> _____
<b>GRADE</b> _____ <b>STUDENT'S ADDRESS</b> _____		
<b>CITY</b> _____		<b>STATE</b> _____ <b>Zip</b> _____
<b>TELEPHONE #</b> _____		<b>DATE OF ENROLLMENT</b> _____
<b>PARENT OR GUARDIAN'S EMAIL ADDRESS</b> _____		
<b>NAME OF PARENT OR GUARDIAN (PLEASE PRINT)</b> _____		
<b>SIGNATURE OF PARENT OR GUARDIAN</b> _____		

GA-15-KEF

## PLEASE REMEMBER TO:



COMPLETE THE ENROLLMENT FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.



MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE ENROLLMENT FORM WITH YOUR CHECK OR MONEY ORDER TO:



**STUDENT PROTECTIVE AGENCY**  
300 Coshocton Avenue  
Mount Vernon, OH 43050



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



# **NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM**

## **INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM**

- The claim form must be completed and signed by the Organization **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Group or Association name on the claim form. Also, the "Authorization To Permit Use and Disclosure of Health Information" must be signed.
- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your policy for the "Initial Treatment Period".
- **PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED WITHIN 90 DAYS OF THE ACCIDENT. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED WITHIN 90 DAYS OF TREATMENT.**
- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
  - 1) **The date(s) of treatment,**
  - 2) **The type(s) of service,**
  - 3) **The diagnosis,**
  - 4) **The medical provider's name and address**
  - 5) **The individual charge for each expense.**
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement. **Please note:** This is not necessary if you have purchased a "Primary" plan through GTL that pays regardless of other insurance payments.
- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

### **GUARANTEE TRUST LIFE INSURANCE COMPANY**

**P.O. Box 1148  
Glenview, Illinois 60025**

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

### **IMPORTANT:**

**Please take note that your claim will result in a processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.**

*If you have any questions, please contact our Customer Service Department at (800) 622-1993.*

NAME OF SCHOOL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY NO. \_\_\_\_\_

IMPORTANT! THIS INFORMATION  
MUST BE GIVEN OR CLAIM WILL  
BE RETURNED

GUARANTEE TRUST LIFE INS. CO.  
P.O. Box 1148  
Glenview, IL 60025  
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: \_\_\_\_\_ Hosp.: \_\_\_\_\_ Other: \_\_\_\_\_  
Addr: \_\_\_\_\_ Addr: \_\_\_\_\_ Addr: \_\_\_\_\_

City State Zip City State Zip City State Zip

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

DATE \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_  
Claimant – if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. Claimant's FULL NAME \_\_\_\_\_ Alternate Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_
2. Claimant's Address: Street or RFD \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Date of Accident \_\_\_\_\_ 20\_\_\_\_ Hour \_\_\_\_\_ AM ☐ PM ☐
4. Description of Accident: (A) How and where did in occur? \_\_\_\_\_  
(if more space needed, attach separate sheet)  
(B) Nature of Injury \_\_\_\_\_
5. Description of Activity (What was the Claimant doing at time of injury?) \_\_\_\_\_  
If Athletics, name sport \_\_\_\_\_ Intramural ☐ Interscholastic ☐ Other ☐
6. (A) On date of accident what time did school start for this student? \_\_\_\_\_ AM ☐ PM ☐  
(B) What time was student dismissed from school? \_\_\_\_\_ AM ☐ PM ☐
7. Has a previous claim been filed for this accident? Yes ☐ No ☐
8. (A) Name of School Authority supervising Activity \_\_\_\_\_  
(B) Was Supervisor a witness? Yes ☐ No ☐  
(C) If not, when was accident reported to School Authority? \_\_\_\_\_

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary ☐ Jr. High ☐ High ☐ Other ☐

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report \_\_\_\_\_ Signature of Official \_\_\_\_\_ Title \_\_\_\_\_

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH  
AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY? ☐ NO ☐ YES

IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:

Insurance Company Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Policy # \_\_\_\_\_

10. Parents Name: Father \_\_\_\_\_ Mother \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Claimant, or Parent if Claimant is a minor)

**Note: Your State Insurance Department requires us to notify you that:** 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.