2023 – 2024 Student Accident Insurance Coverage

Your school has purchased Student Accident Insurance that covers supervised and sponsored school activities. This brochure provides you with the opportunity to extend the accident insurance coverage purchased by your school, as explained below.

Optional 24 hour accident coverage

Insurance coverage is extended to provide for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. The extended accident coverage provides coverage during the weekends and Vacation periods, including the entire summer. Students are protected while at home or away, any place, any time, anywhere. No coverage is provided while participating in 1) Interscholastic Sports or 2) school sponsored and supervised activities that are already covered under the Student Accident Insurance program purchased by the school.

Annual Premium

Standard Plan - $32.00 **Intermediate Plan - $59.00** **Premier Plan - $155.00**

Optional 24-Hour Accident – Summer Only coverage, Students Only

Summer begins on the first day after the school year ends.
Summer ends the first day of the next school year.

Standard Plan - $14.00 **Intermediate Plan - $26.00** **Premier Plan - $61.00**

Optional 24 hour dental coverage (Can be purchased separately or with other coverage)

Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 24 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $50,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.

Annual Premium: $8.00

Coverage period

Coverage under the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on 1) the date you complete your enrollment on-line and your premium is paid, or 2) the date your enrollment form and premium payment are received by the agent, but not before the first day of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends at midnight on the day before school reopens for the following school year. Coverage is available under these plans throughout the school year at the premiums quoted. There are no pro rata premiums available.

Coverage Basis: Primary

Benefits are payable for covered medical expenses from the first dollar of expense incurred. Benefits are paid in addition to and without regard to payments from other insurance.

Accident Medical Expense benefits

When a covered accident results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of the accident, the Company will pay the benefit as shown in the Schedule of Benefits. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident will not exceed the Maximum Benefits stated in the Schedule of Benefits for the Plan purchased. Expenses incurred after one year from the date of the accident are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of the accident.

Accident Death & Dismemberment benefits

When a covered Injury results in any of the Losses stated in the Schedule of Benefits for Accidental Death or Dismemberment, then the Company will pay the benefit stated in the schedule for that Loss. The Loss must occur within 365 days after the date of the Accident.
The maximum benefit as stated in the Schedule of Benefits under Maximum Benefits, is payable for the following Losses:

1) Life; 2) Both Hands or Both Feet or Sight of Both Eyes; 3) One Hand and One Foot; 4) One Hand and Entire Sight of One Eye; 5) One Foot and Entire Sight of One Eye. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot, the Sight of one eye or the loss of Thumb and Index Finger of the Same Hand. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body.

If the Insured suffers more than one of the above covered losses as a result of the same Accident, the total amount the Company will pay is the maximum benefit. Benefits are paid in addition to any other benefits provided by the Policy.

Definitions

A **Covered Accident** means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in an injury or loss. The Accident must occur while the Policy is in force and while the Insured is covered under the Policy. **Usual and Customary** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

Exclusions

Benefits will not be paid for injuries caused by: 1) suicide, intentionally self-inflicted injury, or any attempt thereat while sane or insane; 2) treatment of hernia of any kind; 3) travel in or on any on-road or off-road vehicle that does not require motor vehicle licensing; 4) commission or attempt to commit a felony or an assault, or commission of or active participation in a riot or insurrection; 5) declared or undeclared war or act of war; 6) services or treatment provided by persons who do not normally charge for services, unless there is a legal obligation to pay; 7) flight in, boarding or alighting from an aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline; 8) bungee-cord jumping, parachuting, skydiving, parasailing or hang-gliding; 9) an accident if the insured is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless the insured holds a valid learner's permit and the insured is receiving instruction from a driver's education instructor; 10) services or treatment rendered by any person who is employed or retained by the policyholder or living in the insured's household: a parent, sibling, spouse or child either of the insured or the insured's spouse or the insured; 11) cosmetic surgery, except for reconstruction surgery needed as the result of a covered injury; 12) injuries compensable under workers' compensation law or any similar law; 13) sickness, disease, bodily or mental illness, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound, or accidental ingestion of contaminated food; 14) the insured being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred or voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage; 15) any hospital stay or days of a hospital stay that are not appropriate treatment for the condition and locality; 16) treatment of injury resulting from a condition that the insured knew existed on the date of a covered accident, unless the company has received a written medical release from his physician; 17) injury sustained as a result of practice or play in any Interscholastic Sports or injuries covered under the Student Accident Insurance program purchased by the school.

Retain this description for your records

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This information is a brief description of the important features of this insurance plan. It is not a contract. Terms and conditions of coverage are set forth on policy form series BAM-03-1000.00, or applicable state versions, underwritten by QBE Insurance Corporation. This Blanket Accident Medical Insurance Policy is subject to the laws of the jurisdiction in which it is issued. Additional exclusions and limitation may apply. You may review a copy of the policy upon request.

How to file a claim

In the event of an Accident, students should notify school immediately. To file a claim, obtain a claim form from the school, attach bill(s) to the completed claim form and mail to the address indicated on the form.

Call the Claim Administrator below with any claims questions.

Claims for benefits must be filed within 90 days from the date of the accident, or as soon as reasonably possible.

Program Manager:

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

Toll Free: **888.574.6288**

Claim Administrator:

Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, TX 75024

Toll Free: **866.409.5734**

Schedule of Benefits

Coverage for Injuries due to Accidents only

Maximum Benefits:	**Standard Plan**	**Intermediate Plan**	**Premier Plan**
School-Time Option	$25,000	$25,000	$25,000
24-Hour Option	$25,000	$25,000	$25,000
Football Option	$25,000	$25,000	$25,000
Accidental Death Benefit / Double Dismemberment	$10,000 / $15,000	$10,000 / $15,000	$10,000 / $15,000
Single Dismemberment	$5,000	$5,000	$5,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D Benefits	1 Year	1 Year	1 Year
Accident Medical Coverage Basis	Primary	Primary	Primary
Covered Expenses:			
Hospital/Facility Services – Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	$150 Max per day	$200 Max per day	80% U&C*
Inpatient Hospital Miscellaneous	$500 Max per day	$1,000 Max per day	80% U&C*
Registered Nurses' Services	75% U&C*	80% U&C*	80% U&C*
Physician's Visits (One visit/day max; only applies to non-surgical visits)	$30 first visit / $25 each subsequent visit	$50 first visit / $30 each subsequent visit	80% U&C*
Hospital/Facility Services – Outpatient			
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	$750 Maximum	$1,000 Maximum	80% U&C* / $5,000 Maximum
Hospital Emergency Treatment	$150 Maximum	$250 Maximum	80% U&C*
Physician's Services			
Surgical Fees	$750 Maximum	$1,000 Maximum	80% U&C* / $5,000 Maximum
Assistant Surgeon &/or Anesthesiologist	20% of Surgical Benefits	25% of Surgical Benefits	80% U&C*
Consultant	$200 Maximum	$400 Maximum	80% U&C*
Physician's Visits (One visit/day max; only applies to non-surgical visits; excludes physical therapy)	$30 first visit / $25 each subsequent visit	$50 first visit / $30 subsequent visit	80% U&C* / $50 per day maximum
Physician's Outpatient Treatment in connection with Physical Therapy (One visit/day max)	$30 first visit / $20 each subsequent visit / 5 Visits Max.	$40 first visit / $30 each subsequent visit / 5 Visits Max.	80% U&C* / $50 per day max / 15 Visits Max.
Other Services			
Prescriptions - outpatient	$50 Maximum	$100Maximum	80% U&C*
X-rays, including interpretation - outpatient	$200 Maximum	$400 Maximum	80% U&C*
Diagnostic Imaging (MRI, CAT Scan, etc) including interpretation – outpatient	$200 Maximum	$400 Maximum	80% U&C* / $1,200 Maximum
Laboratory	$50 Maximum	$150 Maximum	80% U&C* / $600 Maximum
Ambulance	$200 Max.	$500 Max.	80% U&C*
Durable Medical Equipment (including Orthopedic Braces & Appliances)	$75 Maximum	$100 Maximum	80% U&C*
Replacement of eyeglasses, hearing aids, contact lenses if medical treatment is also received for the covered injury	100% U&C*	100% U&C*	100% U&C*
Dental Treatment to sound, natural teeth due to covered injury	$100/tooth	$300/tooth	80% U&C*

* U&C means Usual & Customary expense

Coverage Selected: **(Keep for your records)**		
Standard Plan	☐ 24-Hour Accident $32.00	☐ 24-Hour Summer Only $14.00
Intermediate Plan	☐ 24-Hour Accident $59.00	☐ 24-Hour Summer Only $26.00
Premier Plan	☐ 24-Hour Accident $155.00	☐ 24-Hour Summer Only $61.00
	☐ 24-Hour Extended Dental $8.00	

Enrollment

To enroll for coverage with a credit card, please go to www.k12studentinsurance.com

You can also enroll by **using the form below. Just cut along the dotted line, complete the form and mail it, along with your check or money order, to the following address:**

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

QUESTIONS?
Call Toll-free: 888.574. 6288

If you are enrolling more than one Student, please complete a separate form for each Student.
Do not send cash.

2023 – 2024 ENROLLMENT FORM (please print or type)

Student's Last Name | Student's First Name | Student's Middle Initial | Grade

Address | City | State | Zip

Telephone Number | Birthdate

Email Address

School System or School District | Name of School

Check your selection below.

Standard Plan	☐ 24-Hour Accident $32.00	☐ 24-Hour Summer Only $14.00
Intermediate Plan	☐ 24-Hour Accident $59.00	☐ 24-Hour Summer Only $26.00
Premier Plan	☐ 24-Hour Accident $155.00	☐ 24-Hour Summer Only $61.00
	☐ 24-Hour Extended Dental - $8.00	

Please make check or money order payable to: QBE Insurance Corporation.

Total Enclosed:

Signature of Parent or Guardian | Date

Student I.D. Card

Please fill-in the information below and cut along the dotted lines.

2023 – 2024 Student I.D. Card

Name of School: | School District:

Student Name:

CLAIM QUESTIONS: CALL 866.409.5734

Cobertura del seguro estudiantil contra accidentes 2023-2024

Su escuela ha contratado el seguro estudiantil contra accidentes que cubre actividades patrocinadas y supervisadas por la escuela. Este folleto le proporciona la oportunidad de ampliar la cobertura del seguro contra accidentes contratado por su escuela, tal y como se explica a continuación.

Cobertura opcional contra accidentes las 24 horas

La cobertura del seguro se amplía para proporcionar protección contra lesiones ocurridas durante las horas y los días escolares y durante la asistencia y la participación en actividades patrocinadas y supervisadas por la escuela tanto dentro como fuera de las instalaciones escolares. La cobertura ampliada de accidentes proporciona cobertura durante los fines de semana y los periodos de vacaciones incluido todo el verano. Los estudiantes están protegidos mientras están en sus hogares o fuera de los mismos, en cualquier lugar y en cualquier momento. No se proporciona cobertura durante la participación en 1) deportes interescolares o 2) actividades patrocinadas y supervisadas por la escuela que ya están cubiertas por el programa del seguro estudiantil contra accidentes contratado por la escuela.

Prima anual

Plan estándar - $32.00 **Plan intermedio - $59.00** **Plan premier - $155.00**

Cobertura opcional contra accidentes las 24 horas – Cobertura solamente durante el verano, únicamente para estudiantes

El verano comienza el primer día después de que finalice el año escolar.
El verano finaliza el primer día del siguiente año escolar.

Plan estándar - $14.00 **Plan intermedio - $26.00** **Plan premier - $61.00**

Cobertura dental opcional las 24 horas (puede contratarse por separado o con otra cobertura)

La cobertura tiene vigencia las 24 horas del día. Se debe tratar la lesión dentro de los 60 días después de ocurrido el accidente. Los beneficios se abonan dentro de los 24 meses posteriores a la fecha de la lesión. El límite máximo de gastos aprobados a pagar por lesión cubierta asciende a $50,000. Además, en los casos en que el odontólogo certifique que se debe posponer el tratamiento hasta después del Periodo de Beneficios, se pagarán los beneficios diferidos hasta una cantidad máxima de $1,000. El estudiante deberá recibir tratamiento de un odontólogo legalmente certificado, que no sea su familiar directo. La cobertura se limita al tratamiento de los dientes sanos y naturales.

Prima anual: $8.00

Periodo de cobertura

La cobertura opcional contra accidentes las 24 horas y la cobertura dental opcional las 24 horas entran en vigencia en 1) la fecha en la que complete su suscripción en línea y pague su prima, o 2) la fecha en la que el agente reciba su formulario de inscripción y el pago de la prima, pero no antes del primer día del año escolar. La cobertura opcional contra accidentes las 24 horas y la cobertura dental opcional terminan cuando la escuela reinicia sus actividades el siguiente año escolar. La cobertura se encuentra disponible conforme a los planes descritos durante todo el año escolar según las primas cotizadas.

(Las primas prorrateadas no se encuentran disponibles).

Cobertura primaria: Primaria

Se pagarán los beneficios por los gastos médicos cubiertos desde el primer dólar del gasto en el que se incurra. Los beneficios se pagan de manera adicional a cualquier otro pago que pueda recibirse de otro seguro.

Beneficios por gastos médicos por accidente

Cuando un accidente cubierto por la póliza resulte en 1) un tratamiento impartido por un médico o cirujano legalmente cualificado (que no sea familiar directo del estudiante ni una persona contratada por la escuela) o 2) la hospitalización del asegurado para recibir un tratamiento dentro de los 60 días posteriores a la fecha de la lesión, la Compañía pagará los beneficios según lo indicado en la Tabla de Beneficios. Solamente se cubrirán los gastos médicos elegibles en los que incurrió el Asegurado dentro de las 52 semanas a partir de la fecha del accidente. Los beneficios para cualquier accidente no excederán en total la cantidad máxima establecida en la Tabla de Beneficios del Plan contratado. No se cubrirán los gastos en los que se incurra después de un año a partir de la fecha de la lesión, aunque el servicio sea continuo o sea necesario demorarlo pasado un año desde la fecha de la lesión.

Beneficios por muerte accidental y desmembramiento

Cuando una lesión cubierta por la póliza resulta en cualquiera de las pérdidas establecidas en la Tabla de Beneficios por muerte accidental o desmembramiento, la Compañía pagará los beneficios establecidos en la tabla para dicha pérdida. La pérdida debe haberse sufrido dentro de los 365 días posteriores a la fecha del accidente.

El beneficio máximo a pagar se establece en la Tabla de Beneficios en el punto Beneficios Máximos, y cubre las siguientes pérdidas:

1) Vida; 2) ambas manos o ambos pies, o la vista en ambos ojos; 3) una mano y un pie; 4) una mano y la vista completa en un ojo; 5) un pie y la vista completa en un ojo. Se pagará la mitad del beneficio máximo por la pérdida de una mano, un pie o la vista en un ojo o la pérdida del dedo pulgar y dedo índice de la misma mano. Pérdida de la mano o pie significa la amputación total a la altura o por encima de la muñeca o la articulación del tobillo. Pérdida de la vista significa la pérdida completa y permanente de la vista en un ojo. La pérdida de la vista debe ser irrecuperable por medios naturales, quirúrgicos o artificiales. Pérdida del pulgar e índice de la misma mano significa la amputación total a la altura o por encima de las articulaciones metacarpofalángicas de la misma mano (las articulaciones entre los dedos y la mano). Amputación significa la separación total y el desmembramiento de una parte del cuerpo.

Si el Asegurado sufre más de una de las pérdidas cubiertas mencionadas anteriormente como resultado del mismo accidente, la cantidad total que pagará la Compañía será la cantidad del beneficio máximo. Los beneficios se pagarán de manera adicional a cualquier otro beneficio proporcionado por la Póliza.

Definiciones

Accidente cubierto significa un evento repentino, inesperado y externo que resulta, directamente e independientemente de todas las demás causas, en una lesión o pérdida. El accidente debe ocurrir durante el periodo de vigencia de la Póliza y mientras el Asegurado está cubierto por la misma. **Gastos razonables** significa el promedio que cobran la mayoría de los proveedores por el tratamiento, los servicios e insumos dentro del área geográfica donde se proporciona el tratamiento, el servicio y los insumos. Dichos servicios e insumos deben ser recomendados y aprobados por un médico.

Exclusiones

No se pagarán beneficios por lesiones causadas por: 1) suicidio, lesión autoinfligida intencionalmente, o cualquier intento similar, esté la persona en su sano juicio o no; 2) tratamiento de hernia de cualquier tipo; 3) viajar en un vehículo estándar o un vehículo motorizado recreativo que no requiere licencia de vehículo motorizado; 4) cometer o intentar cometer un delito grave o agresión, o por iniciar o participar activamente de un disturbio o insurrección; 5) guerra declarada o no declarada o acto de guerra; 6) servicios o tratamiento proporcionado por personas que no cobran usualmente por servicios, a menos que exista la obligación legal de pagar; 7) realizar un vuelo, embarcar en o descender de una aeronave excepto que el Asegurado sea un pasajero que haya pagado su boleto en una aerolínea comercial o un vuelo chárter regular; 8) practicar bungee-jumping (puenting), paracaidismo, paracaidismo con caída libre, parapente, parasailing, ala delta; 9) un accidente si el asegurado es el operador de un vehículo motorizado y no posee una licencia válida de conductor del vehículo motorizado, a menos que posea un permiso de aprendiz válido y reciba instrucciones del instructor de manejo; 10) servicios o tratamiento proporcionado por cualquier persona empleada o contratada por el titular de la póliza o que resida en la residencia del asegurado: un padre, un hermano, un cónyuge o niño del asegurado o del cónyuge del asegurado o el asegurado; 11) cirugía estética, excepto la cirugía reconstructiva necesaria como resultado de una lesión cubierta por la póliza; 12) lesiones cubiertas conforme a la ley de indemnización laboral o cualquier ley similar; 13) enfermedad, dolencia, enfermedad corporal o mental, infección bacteriana o viral o tratamiento médico o quirúrgico que de allí resulte, excepto cualquier infección bacteriana que resulte de un corte o herida externa accidental, o una ingestión accidental de alimentos contaminados; 14) por estar legalmente intoxicado según lo establecido en las leyes del estado en el cual ocurra la lesión o por la ingestión voluntaria de estupefacientes, drogas, veneno, gas o escapes, a menos que sean recetados o se tomen por instrucción de un médico y de acuerdo con la dosificación prescrita; 15) cualquier estancia en hospital o días de estancia en hospital que no correspondan al tratamiento apropiado por la afección y su ubicación; 16) tratamiento de la lesión que resulte de una afección que el asegurado conocía el día en que se produce una lesión cubierta por la póliza, a menos que la compañía haya recibido el alta médica por escrito de su médico; 17) lesión sufrida como resultado de una práctica o participación en cualquier deporte interescolar, o lesiones cubiertas por el seguro estudiantil contra accidentes.

Conserve esta descripción para sus registros

AVISO IMPORTANTE – ESTA PÓLIZA NO OFRECE COBERTURA POR ENFERMEDAD. La información aquí descrita es una reseña de los aspectos importantes de esta póliza de seguro. No es un contrato. Los términos y condiciones de la cobertura se especifican en el formulario de póliza serie BAM-03-1000.00, o sus versiones correspondientes según el estado, suscrito por QBE Insurance Corporation. Esta póliza ampliada de seguro médico por accidentes se encuentra sujeta a las leyes de la jurisdicción donde fue emitida. Pueden aplicarse exclusiones y limitaciones adicionales. Puede solicitar una copia de la póliza.

Cómo presentar una reclamación

En caso de accidente, los estudiantes deberán notificarlo a la escuela de inmediato. A fin de presentar una reclamación, deberá solicitar un formulario de reclamaciones a la escuela, adjuntar al formulario completo el o los recibos de pagos efectuados y enviarlo por correo a la dirección indicada en el formulario.

Llamar al Administrador de Reclamaciones que se indica abajo para cualquier consulta sobre reclamaciones.

Las reclamaciones de beneficios deben presentarse dentro de los 90 días posteriores a la fecha del accidente o tan pronto como sea posible.

Gerente del programa:

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

Línea gratuita: **888.574.6288**

Administrador de reclamaciones:

Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, TX 75024

Línea gratuita: **866.409.5734**

Tabla de beneficios

Cobertura de lesiones por accidentes solamente

Beneficio máximo:	**Plan estándar**	**Plan intermedio**	**Plan premier**
Opción Escolar	$25,000	$25,000	$25,000
Opción 24 horas	$25,000	$25,000	$25,000
Opción Fútbol Americano	$25,000	$25,000	$25,000
Beneficio por muerte accidental / desmembramiento doble	$10,000 / $15,000	$10,000 / $15,000	$10,000 / $15,000
Desmembramiento único	$5,000	$5,000	$5,000
Periodo de pérdida para recibir los beneficios médicos	El tratamiento debe comenzar dentro de los 60 días posteriores a la fecha de la lesión		
Periodo para beneficios médicos, por muerte accidental y desmembramiento	1 año	1 año	1 año
Cobertura médica primaria por accidentes	Primaria	Primaria	Primaria
Gastos cubiertos:			
Servicios de hospital/centro médico - Hospitalización			
Habitación y alimentos en el hospital (tarifa de habitación semi privada)	$150 máx. por día	$200 máx. por día	80% GR*
Servicios varios para pacientes hospitalizados	$500 máx. por día	$1,000 máx. por día	80% GR*
Servicios de enfermera matriculada	75% GR*	80% GR*	80% GR*
Consultas médicas (Una consulta/día máx.; solo aplicable a visitas no quirúrgicas)	$30 primera consulta / $25 cada consulta subsiguiente	$50 primera consulta / $30 cada consulta subsiguiente	80% GR*
Servicios de hospital/centro médico - Ambulatorio			
Servicios varios para pacientes ambulatorios (excepto los servicios del médico y las radiografías, que se especifican a continuación)	$750 máximo	$1,000 máximo	80% GR* / $5,000 Máximo
Tratamiento en sala de emergencias del hospital	$150 máximo	$250 máximo	80% GR*
Servicios del médico			
Gastos quirúrgicos	$750 máximo	$1,000 máximo	80% GR* / $5,000 máximo
Cirujano auxiliar y/o anestesiólogo	20% de beneficios quirúrgicos	25% de beneficios quirúrgicos	80% GR*
Asesor médico	$200 máximo	$400 máximo	80% GR*
Consultas médicas (Una consulta/día máx.; solo aplicable a visitas no quirúrgicas; no incluye terapia física)	$30 primera consulta / $25 cada consulta subsiguiente	$50 primera consulta / $30 cada consulta subsiguiente	80% GR* / $50 por día máximo
Tratamiento médico ambulatorio relacionado con Terapia física (Una consulta/día máx.)	$30 primera consulta / $20 cada consulta subsiguiente / 5 consultas máx.	$40 primera consulta / $30 cada consulta subsiguiente / 5 consultas máx.	80% GR* / $50 por día máximo / 15 consultas máximo
Otros servicios			
Recetas - ambulatorio	$50 máximo	$100 máximo	80% GR*
Radiografías, con informe - ambulatorio	$200 máximo	$400 máximo	80% GR*
Diagnóstico por imágenes (resonancias magnéticas, tomografías computarizadas, etc.) con informe - ambulatorio	$200 máximo	$400 máximo	80% GR* / $1,200 máximo
Laboratorio	$50 máximo	$150 máximo	80% GR* / $600 máximo
Ambulancia	$200 máx.	$500 máx.	80% GR*
Equipo médico de larga duración (incluidos soportes y aparatos ortopédicos)	$75 máximo	$100 máximo	80% GR*
Reemplazo de gafas, audífonos, lentes de contacto, si además se recibe tratamiento médico para la lesión cubierta	100% GR*	100% GR*	100% GR*
Tratamiento dental para los dientes sanos y naturales a causa de una lesión cubierta	$100/diente	$300/diente	80% GR*

* GR significa Gastos razonables

Cobertura elegida: **(Consérvese para sus registros)**

Plan estándar	☐ Accidente las 24 horas $32.00	☐ Accidente las 24 horas solo en verano $14.00
Plan intermedio	☐ Accidente las 24 horas $59.00	☐ Accidente las 24 horas solo en verano $26.00
Plan premier	☐ Accidente las 24 horas $155.00	☐ Accidente las 24 horas solo en verano $61.00
	☐ Cobertura dental ampliada las 24 horas $8.00	

Suscripción

Para solicitar la cobertura con tarjeta de crédito, diríjase a www.k12studentinsurance.com.

También puede suscribirse **utilizando el formulario que se muestra a continuación. Recorte el formulario por la línea punteada, complételo y envíelo por correo junto con su cheque u orden de pago, a la siguiente dirección:**

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

¿PREGUNTAS?
Línea gratuita: 888.574.6288

Si desea inscribir a más de un estudiante, complete un formulario distinto para ese estudiante. **No envíe dinero en efectivo.**

FORMULARIO DE INSCRIPCIÓN 2023 – 2024 (completar a máquina o en letra mayúscula)

Apellido del estudiante: | Nombre del estudiante: | Inicial del segundo nombre del estudiante: | Grado

Dirección | Ciudad | Estado | Código postal

Número telefónico | Fecha de nacimiento

Email

Sistema escolar o distrito escolar | Nombre de la escuela

Marque la opción elegida.

Plan estándar	☐ Accidente las 24 horas $32.00	☐ Accidente las 24 horas solo en verano $14.00
Plan intermedio	☐ Accidente las 24 horas $59.00	☐ Accidente las 24 horas solo en verano $26.00
Plan premier	☐ Accidente las 24 horas $155.00	☐ Accidente las 24 horas solo en verano $61.00
	☐ Cobertura dental ampliada las 24 horas $8.00	

Efectuar los cheques o pagos en efectivo a la orden de: QBE Insurance Corporation.

Total adjunto:

Firma del padre/madre o tutor | Fecha

Tarjeta de identificación de estudiante

Por favor, complete la información que se requiere a continuación y recorte por las líneas punteadas.

Tarjeta de identificación estudiante 2023 – 2024

Nombre de la escuela: | Distrito escolar:

Nombre del estudiante:

PREGUNTAS SOBRE RECLAMACIONES: LLAME AL 866.409.5734

ENROLL ONLINE NOW at www.k12studentinsurance.com

K-12 STUDENT ACCIDENT INSURANCE PLANS

How to Enroll

Enrolling online is easy & takes only a few minutes. Go to www.k12studentinsurance.com

1. **Browse** the available Plans and Rates.
2. **Pick your State** -see if your School is available.
3. **Open New Account** - Once you have determined your school is covered, you'll need to open a new account for this school year (you must create a new account each school year).
   If you have created your account for this year, please remember your **User ID and Password**.
4. **Add Student** & **Coverage** by clicking on the "Add Student" button on top of page.
   Continue *to add each student by clicking on the "Add Student" button until all your students are added.*
5. Select "**Checkout**".
6. Select your **payment type** and click "Continue Checkout".
7. Enter **billing information** and click "Continue Checkout".
8. Click "Pay and View Receipt" to **complete your order.**
9. **Coverage** is effective when payment is **"Confirmed". Effective Date** will be shown on your **ID CARD.**
10. **Save your receipt** for future reference.

If you have questions, please call us at **1-888-574-6288.**

Accident coverage underwritten by QBE INSURANCE CORPORATION

Inscribase ahora en www.k12studentinsurance.com

K-12 PLANES DE COBERTURA DE ACCIDENTES DE SEGURO PARA ESTUDIANTES

COMO INSCRIBIRSE

Inscribirse en linea, es tan censillo, y solamente toma unos minutos.

Por favor entre a la pagina www.k12studentinsurance.com

1. **Revise** los planes y las tarifas disponibles.
2. Elija su Estado y confirme que su escuela este disponible por el año escolar en curso
3. **Abrir una Nueva Cuenta-** Una vez que haya verificado que su escuela ofrece cobertura, devera abrir una nueva cuenta para el año escolar en curso. (Devera crear una nueva cuenta cada año escolar). Si ya ha creado su cuenta para el año en curso…**recuerde su identificacion de usuario y la contraseña.**
4. Agregue el nombre del estudiante y la cobertura, oprimiendo el boton "add student" al final de la pagina. *Continue agregando los nombres por cada estudiante, hasta terminar con todos los nombres necesarios.*
5. Seleccione el boton de "**checkout**"
6. Seleccione su forma de pago oprimiendo el boton "**continue checkout**" al final de la pagina para continuar con el pago
7. Llene la dirección a donde recive su correspondencia y oprima el boton "**continue checkout**" al finial de la pagina.
8. Para continuar con su orden, oprima el boton "**Pay and View Receipt**".
9. La cobertura comienza cuando el pago sea **"Confirmado". La fecha** aparecerá en la tarjeta de **identificación**.
10. Guarde su recivo como **referencia**, por si lo necesita en el futuro.

Si tiene preguntas por favor llámenos al: 1 888-574-6288.

Cobertura de accidente suscrita por QBE Insurance Corporation

QBE

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills (UB04 or HCFA-1500 form)
3. Mail, Email or Fax to *HSR*

Email: K12claims@hsri.com

HSR
Health Special Risk, Inc.

P.O. Box 250649
Plano, Texas 75025-0649
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734

School District: Davie County

School Name:

Policy Number: SHH100032 | SHH100033 | SHH910052

District Paid x Voluntary x

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail

6. Address of Injured Person	7. Phone Number (include area code)
8. Parent/Legal Guardian Name, Address, City, State & Zip	9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g., broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:		
☐ Play or practice of interscholastic sports	☐ During lunch hour	☐ Athletic period
☐ Not school related	☐ In school bus	☐ On school property during school hours
☐ P.E. class	☐ School sponsored field trip	☐ School sponsored activity during school hours
	☐ Traveling to/from school	☐ ROTC activity

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

Signature of Parent/Legal Guardian:		Signature of School Official:	
X	Date:	X	Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.
New York Fraud Warning Notice: 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 material 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.

Signature of Parent/Legal Guardian:		Signature of Witness:	
X	Date:	X	Date:

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD WARNING NOTICES

Any person who knowingly presents a false of fraudulent claim for payment of 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.

STATE SPECIFIC PROVISIONS

Alabama	Any person who knowingly 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	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.
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.
Arkansas **Louisiana**	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.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware **Idaho**	Any person who knowingly, 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.
District of Columbia	WARNING: 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.
Florida	Any person who knowingly 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.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Indiana	A person who knowingly and with intent to defraud an insurer. files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	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.
Maine	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 denial of insurance benefits.
Maryland	Any person who knowingly and 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.
Michigan **North Dakota** **South Dakota**	Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty o f a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
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 RSA638:20
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	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 civil fines and criminal 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	WARNING: 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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
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.
Rhode Island **West Virginia**	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.
Tennessee **Virginia** **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 include imprisonment, fines and denial of insurance benefits.
Texas	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.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to ***HSR*** at the address shown below.
3. **The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.**
4. Due to HIPAA Privacy laws ***HSR*** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim. ***HSR*** cannot pay your bills using only the Primary Insurance Carrier's EOB.

EXCESS INSURANCE

1. If the policy provides coverage on a secondary/excess basis and you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. to 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818 or email to K12claims@hsri.com.

Health Special Risk, Inc.
P.O. Box 250649
Plano, Texas 75025-0649