



Underwritten by:  
**AXIS Insurance Company**  
 Serviced by:  
 K&K Insurance Group, Inc.

# MANDATORY & VOLUNTARY BLANKET MASTER INSURANCE APPLICATION

Coverage not available in the following states: AR, MD, NH, NY, WA

Application is hereby made for a plan of **BLANKET ACCIDENT INSURANCE** based on the following statements and representations:

Policyholder: Name of School/District Gahanna Jefferson Public Schools  
 Requested Effective Date: 8/1/23 Requested Termination Date (one year from the Requested Effective Date): 7/31/24  
 Street Address: 1100 S. Hamilton Rd  
 City: Gahanna State: OH Zip: 43230  
 Mailing Address (if different): \_\_\_\_\_  
 Contact Name: Kristin Starr Title: Secretary of Special Programs  
 Phone: 614-479-1310 Fax: \_\_\_\_\_  
 Email: starrk@GJPS.org

### Mandatory Accident Coverage (Coverage selected by school/district)

Product Option	Grades	Total # of Insured	Rate	Premium
At-School Including Athletics & Activities				
At-School Excluding Athletics & Activities				
Athletics & Activities				
Field Trip				
School Band				
JROTC				
Other (Please Specify)				
Other (Please Specify)				
Other (Please Specify)				
<b>Total Mandatory Premium Due:</b>				_____

### Voluntary Accident Coverage

Estimated annual school enrollment (total number of students): 7957  
 Grades (mark one):  PK-12     Elementary School     Middle School     High School  
 Effective Date: 8/1/23

The terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. The terms of the policy when issued will govern. It is agreed the insurance applied for will not become effective unless a) this application is received and approved by AXIS Insurance Company based on current rules and requirements; b) the policy is accepted by the applicant; and c) the required premium is paid when due.

The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.

**POLICYHOLDER SIGNATURE**  
[Signature]  
 Authorized Signature of Applicant  
Jo Scott Gooding II, Treasurer / CFO  
 Printed or typed name of Applicant's Authorized Representative  
07/27/2023  
 Date

**LICENSED BROKER/AGENT SIGNATURE**  
[Signature]  
 Licensed Broker/Agent  
18608-001  
 License Number  
7/25/2023  
 Date

1712 Magnavox Way P.O. Box 2338, Fort Wayne, Indiana 46801  
 phone: (855) 742-3135 • www.studentinsurance-kk.com • CA License #0334819

# **IMPORTANT NOTICE - FRAUD WARNING**

- **In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.
- **For Residents of Alabama:** 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 restitution fines and confinement in prison, or any combination thereof.
- **For Residents of California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of 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.
- **For residents of the 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.
- **For residents of Florida:** 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.
- **For residents of Kentucky:** 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.
- **For residents of Maine, Tennessee 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 include imprisonment, fines and denial of insurance benefits.
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- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of Oregon:** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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 false or deceptive statement may have violated state law.



**STUDENT OR ATHLETE  
ACCIDENT CLAIM FORM**  
Excess Coverage  
K-12 ACCOUNTS

**CLAIMS DEPARTMENT**

1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338  
Ph: 800-237-2917 Fax: 312-381-9077 California License #0334819  
email:kk.PAClaims@kandkinsurance.com  
www.kandkinsurance.com

**INSTRUCTIONS FOR FILING**

**NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.**

**Basic Procedures for Submitting Statement of Claim**

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

**To the Student or Athlete/Parent/Guardian**

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

**SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)**

1. Student's Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ Sex:  Male  Female
3. Student's grade in school: \_\_\_\_\_ Email address: \_\_\_\_\_
4. Home Address Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent(s)/Guardian(s) Home Phone: \_\_\_\_\_
5. Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  AM  PM  
Nature of Injury: \_\_\_\_\_ Describe exactly how accident happened: \_\_\_\_\_
6. Nature of activity and location during which the injury occurred (check all boxes which apply):
 

<input type="radio"/> Pre-Kindergarten	<input type="radio"/> Elementary School	<input type="radio"/> Middle School
<input type="radio"/> High School	<input type="radio"/> Cafeteria	<input type="radio"/> Classroom Activities
<input type="radio"/> Interscholastic Sports	<input type="radio"/> Intramural Sports, <i>name of sport, if applicable:</i> _____	<input type="radio"/> Other Activity (specify) _____
<input type="radio"/> Club Sports	<input type="radio"/> Physical Education Class	<input type="radio"/> During Travel To or From the Event
<input type="radio"/> During Practice	<input type="radio"/> During Play	

Nature of Your Participation:

<input type="radio"/> Student	<input type="radio"/> Volunteer	<input type="radio"/> Student/Manager
<input type="radio"/> Athletic Participant	<input type="radio"/> Cheerleader	<input type="radio"/> Band Member
<input type="radio"/> Other (specify) _____		
7. Transfer Student?  Yes  No  
If yes, please identify the former school name: \_\_\_\_\_
8. Name, address and phone number of physician who first treated you: \_\_\_\_\_

9. Have you had a similar injury in the past?  Yes  No

If yes, describe and give dates: \_\_\_\_\_

10. Name, address and phone number of physician who treated you for previous injury: \_\_\_\_\_

11. Are you covered by any other medical expense benefits plan?  Yes  No

If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

**IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE**

**ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.**

## **THIS IS EXCESS MEDICAL COVERAGE**

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

### **SECTION II**

**(TO BE COMPLETED BY PARTICIPATING SCHOOL)**

**FAILURE TO COMPLETE THIS FORM IN FULL  
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM**

1. Student's Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

2. Date of Accident \_\_\_\_\_

3. Activity \_\_\_\_\_

4. Nature of Injury \_\_\_\_\_

5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT \_\_\_\_\_

6. Name of participating SCHOOL \_\_\_\_\_

7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNATURE OF SCHOOL OFFICIAL: \_\_\_\_\_

PRINTED NAME/TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_ DATE: \_\_\_\_\_

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Date \_\_\_\_\_ Policyholder (School Official) Signature \_\_\_\_\_

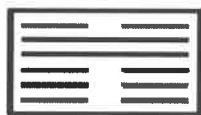
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[AXIS\_FRAUD 0220]

**Dear Participant:** If you have an appointment with a doctor as a result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

**Dear Doctor or Provider:** This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates.



### INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT/GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.





# OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: \_\_\_\_\_ INTERNATIONAL STUDENT  Yes  No  
 EMANCIPATED STUDENT:  Yes  No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT:  Yes  No  
 NAME OF INSURED: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

FATHER	MOTHER
IS FATHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IS FATHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: ( ) _____	PHONE: ( ) _____
CONTACT PERSON: _____	CONTACT PERSON: _____
Do you have group medical insurance coverage through your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have group medical insurance coverage through your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is it: <input type="checkbox"/> Individual <input type="checkbox"/> Family	If Yes, is it: <input type="checkbox"/> Individual <input type="checkbox"/> Family
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COMPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGE <input type="checkbox"/> OTHER (describe) _____	TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGES <input type="checkbox"/> OTHER (describe) _____

**I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.**

PARENT/GUARDIAN/FATHER SIGNATURE: \_\_\_\_\_ PARENT/GUARDIAN/MOTHER SIGNATURE: \_\_\_\_\_  
 DATE: \_\_\_\_\_ DATE: \_\_\_\_\_

**I WAIVE ANY PROMISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPOECT TO THE ACCIDENTAL, INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.**

**I WAIVE ANY PROMISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.**

**I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
 Please Note: If injured person is a minor, signature must be of parent or legal guardian.

**AXIS INSURANCE COMPANY**  
**(A Stock Company)**  
(Herein called the Company)

Administrative Office:  
1 University Square Drive, Suite 200  
Princeton, NJ 08540

Home Office:  
111 South Wacker Drive, Suite 3500  
Chicago, IL 60606

**BLANKET ACCIDENT POLICY/CERTIFICATE**  
**AMENDMENT**

POLICY AMENDMENT NO. 0000

POLICY RENEWAL

POLICYHOLDER: GAHANNA JEFFERSON PUBLIC SCHOOLS

DOING BUSINESS AS:

POLICY NUMBER: KAMV0000018101502

POLICY EFFECTIVE DATE: 08/01/23

POLICY ANNIVERSARY: 08/01

STATE OF ISSUE: OH

This Amendment is attached to and made part of the Policy effective 08/01/23 at 12:01 AM, Standard Time. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

It is hereby understood and agreed the Policy is renewed for a period of one year, commencing 08/01/23 and ending 08/31/24 .

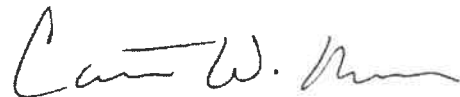
**Renewal Premium:** AS REPORTED

This Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Amendment.

The President and Secretary of AXIS Insurance Company witness this Amendment:



Secretary



President

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- **For residents of Oregon:** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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 false or deceptive statement may have violated state law.



# 2023-2024 Student Accident Coverage

Serviced by: K&K Insurance Group, Inc. Phone: 855-742-3135

**Remember to visit our website for faster enrollment: [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com)  
Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.**

**ACCIDENT ONLY COVERAGE:** The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of \$25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

**SCHEDULE OF BENEFITS:** *Maximum Benefits Paid As Specified Below.*

Compare and Choose	Low Option Accident Only	High Option Accident Only
Maximum Benefit:	\$25,000 (For Each Injury)	\$25,000 (For Each Injury)
Deductible:	\$0	\$0
<b>Inpatient Hospital Services</b>		
Room & Board Expenses:	Up to \$150 per day/ Semi-private room rate	80% of Usual and Customary Charges/ Semi-private room rate
Miscellaneous Expenses:	\$600 maximum per day	\$1,200 maximum per day
Physician's Visits: <i>(Limited to one visit per day)</i>	\$40 first day/\$25 each subsequent day	\$60 first day/\$40 each subsequent day
<b>Ambulatory Medical Center</b>		
<b>Emergency Room Treatment:</b> <i>(Treatment must be rendered within 72 hours from the time of the injury)</i>	\$150 maximum	\$300 maximum
Surgery <i>(*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.)</i>	\$1,000 maximum	\$1,200 maximum
Assistant Surgeon	100% of Usual and Customary Charges <i>(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</i>	100% of Usual and Customary Charges <i>(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</i>
Anesthesia and its Administration	100% of Usual and Customary Charges <i>(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</i>	100% of Usual and Customary Charges <i>(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</i>
<b>Outpatient</b>		
Outpatient Physician Visits: <i>(Limited to one visit per day)</i>	\$40 first day/\$25 each subsequent day	\$60 first day/\$40 each subsequent day
Outpatient X-ray:	\$200 maximum	\$600 maximum
Outpatient Diagnostic Imaging Services:	\$300 maximum	\$600 maximum
Outpatient Laboratory:	\$60 maximum	\$300 maximum
Outpatient Physiotherapy: <i>(Limited to one visit per day. Includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)</i>	\$30 first day/\$20 each subsequent day/ 5 days maximum	\$60 first day/\$40 each subsequent day/ 5 days maximum
<b>Ambulance Services:</b> <i>(Air and Ground)</i>	\$300 maximum	\$800 maximum
<b>Medical Equipment Rental:</b> <i>(Includes Orthopedic devices)</i>	\$75 maximum	\$140 maximum
<b>Dental Services:</b>	\$10,000 maximum per policy	\$10,000 maximum per policy term
<b>Prescription Drugs:</b>	\$75 maximum	\$200 maximum
<b>Consultant:</b>	\$200 maximum	\$400 maximum
<b>Replacement of Eye Glasses, Contact Lenses or Hearing Aids:</b>	100% of Usual and Customary Charges	100% of Usual and Customary Charges

**THIS IS A BLANKET ACCIDENT ONLY POLICY.**

*U.S. Insurance coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909, et al. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.*

*The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.*

**THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.**

## Choose Your Coverage Plan:

One-Time Payment For Accident Coverage

### PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW

**Coverage Effective Date:** A person's coverage takes effect at the later of the date his or her completed student accident enrollment form and premium is received by the company or the effective date of the policy issued to his or her school or school district.

**Coverage Termination Date:** Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be an eligible person per the definition below. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

	Low Option	High Option
<b>24-Hour Accident</b> Around-the-clock, Before, during and after school, Weekends, vacation and all summer including summer school, School sponsored and extracurricular sports excluding High School Football.	\$112.00	\$165.00
<b>24-Hour Accident (Summer Only Coverage)</b> Summer begins on the first day after the school year ends. Summer ends the first day of the next school year.	\$39.00	\$51.00
<b>At-School Accident</b> During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes, School Sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.	\$30.00	\$38.00
<b>High School Football (Full Year)</b> Play or practice of regularly scheduled football.	\$176.00	\$293.00
<b>High School Football (Spring Only Rates)</b> For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.	\$76.00	\$124.00
<b>High School Football and At-School Accident (Covers all athletics)</b>	\$206.00	\$331.00
<b>High School Football and 24-Hour Accident (Covers all athletics)</b>	\$288.00	\$458.00

## About Your Coverage

1. ELIGIBLE PERSONS: students of the policyholder who enroll and make the required premium contribution for the coverage selected are Eligible Persons under the Policy. Depending on the coverage selected, coverage may continue after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy is on file with the school district and is a non-renewable policy. The student coverage selected is non-renewable and requires the student to re-enroll each school year.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: Insurance becomes effective for a student who enrolls and makes the required premium contribution on the latest of the following dates:
  - a. the Policy Effective Date;
  - b. the date the Company receives student's completed enrollment form and the required premium payment.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date: he or she is no longer an Eligible Person, the end of the 1 year coverage term or the date the School's policy ends. All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim for a Covered Accident that occurs before the termination date.
6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.
7. CANCELLATION: Your coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company.

## Enroll online at:

[www.StudentInsurance-kk.com](http://www.StudentInsurance-kk.com)

### or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to Axis Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Mail completed enrollment form with payment back to:
 

**K&K Insurance Group,  
P.O. Box 2338  
Fort Wayne, IN 46801-2338**
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

## Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

## Administered by:

K&K Insurance Group, P.O. Box 2338,  
Fort Wayne, IN 46801-2338

**STUDENT INSURANCE CARD**

Student's Name \_\_\_\_\_  
*If premium has been paid, the student whose name appears above has been insured under a Policy issued to:*

School District: \_\_\_\_\_

Accident Only Coverage:  24-HOUR  24-HOUR (Summer Only Coverage)  
 AT-SCHOOL  FOOTBALL  FOOTBALL (Spring Only)  EXTENDED DENTAL

Paid by Check # \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Date Paid: \_\_\_\_\_

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

Underwritten by: AXIS Insurance Company  
 Claims Questions: K&K Insurance Group, Inc.  
 1712 Magnavox Way - Fort Wayne, IN 46801 - 800-237-2917

## COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. 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;
9. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
10. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
11. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
12. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
13. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
14. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
15. benefits will not be paid for services or treatment rendered by any person who is:
  - a. employed or retained by the Policyholder;
  - b. living in the Insured Person's household;
  - c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
  - d. the Insured Person.

## EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. repair or replacement of existing artificial limbs, eyes and larynx;
7. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits.

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

## ACCIDENT ONLY DEFINITIONS:

**Covered Injury** means Accidental bodily injury:

1. which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force;
2. which results directly and independently from all other causes from a Covered Accident; and
3. which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

**Accident or Accidental:** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

**Covered Expenses:** means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

**Medically Necessary:** means medical services that:

1. are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. are ordered by a Physician and performed under His care, supervision or order.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Covered Loss must occur within 365 days of the Covered Accident.

Not more than the Aggregate Limit of \$500,000 will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage. This Aggregate Limit is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit.

COVERED LOSS	BENEFIT AMOUNT
Loss of Life	\$10,000
Loss of Two or More Hands or Feet	\$10,000
Loss of Sight of Both Eyes	\$10,000
Loss of Speech and Hearing (in Both Ears)	\$10,000
Loss of One Hand or Foot and Sight in One Eye	\$10,000
Loss of One Hand or Foot	\$5,000
Loss of Sight in One Eye	\$5,000
Loss of Speech	\$5,000
Loss of Hearing (in Both Ears)	\$5,000
Loss of Hearing in One Ear	\$2,500
Loss of Thumb and Index Finger of the same Hand	\$2,500
Exposure and Disappearance	Included

# Enroll online for quicker service at [www.StudentInsurance-kk.com](http://www.StudentInsurance-kk.com)

or complete and mail this form

## Student Accident Enrollment Form (School Year 2023-2024)

Student's Last Name: \_\_\_\_\_

Student's First Name: \_\_\_\_\_

Student's Middle Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School District (required): \_\_\_\_\_

Name of School: \_\_\_\_\_

Grade Level:  Pre-K/Headstart  Kindergarten/Elementary  Middle School  High School/Above

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Student Insurance Plan Options – Check Your Selection:

Accident Only Coverage Plans	Low Option	High Option
24-HOUR	<input type="checkbox"/> \$112.00	<input type="checkbox"/> \$165.00
24-HOUR Summer Only	<input type="checkbox"/> \$39.00	<input type="checkbox"/> \$51.00
AT-SCHOOL	<input type="checkbox"/> \$30.00	<input type="checkbox"/> \$38.00
HIGH SCHOOL FOOTBALL COVERAGE Full Year	<input type="checkbox"/> \$176.00	<input type="checkbox"/> \$293.00
HIGH SCHOOL FOOTBALL COVERAGE Spring Only <i>For New Players</i>	<input type="checkbox"/> \$76.00	<input type="checkbox"/> \$124.00
HIGH SCHOOL FOOTBALL and AT-SCHOOL <i>Covers all athletics</i>	<input type="checkbox"/> \$206.00	<input type="checkbox"/> \$331.00
HIGH SCHOOL FOOTBALL and 24-HOUR <i>Covers all athletics</i>	<input type="checkbox"/> \$288.00	<input type="checkbox"/> \$458.00

Enclose check for total payment payable to: **AXIS INSURANCE COMPANY**. Checks, money orders, or credit cards accepted.

**DO NOT SEND CASH**

TOTAL ENCLOSED: \$ \_\_\_\_\_

**See Important Notice - Fraud Warning on next page.**

Mail this completed form with payment back to: **K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338**

#### Complete this section only if you wish to pay with a Credit Card

Full name as it appears on card

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Billing Address (if different than above)

Street # \_\_\_\_\_ Address \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card Number:                 Expiration Date: Month:   Year:

Cardholder signature: \_\_\_\_\_

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)

# **IMPORTANT NOTICE - FRAUD WARNING**

- **In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.
- **For Residents of Alabama:** 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 restitution fines and confinement in prison, or any combination thereof.
- **For Residents of California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of 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.
- **For residents of the 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.
- **For residents of Florida:** 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.
- **For residents of Kentucky:** 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.
- **For residents of Maine, Tennessee 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 include imprisonment, fines and denial of insurance benefits.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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.
- **For residents of Oregon:** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- **For residents of 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.
- **For residents of 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.
- **For residents of 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 false or deceptive statement may have violated state law.