insuring the world's fun ®

04/16/2024

THOMAS FALLON
THOMAS B. FALLON
16 RUSTIC RD
UPPER SADDLE RIVER, NJ 07458

Re: Policy Number: KAMV0000018089203
NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL

Dear Sir/Madam,

Thank you for providing the opportunity for K&K Insurance to serve your client's insurance needs.

Enclosed is the insurance coverage document(s). Please carefully review the coverages, limits and exclusions and contact me immediately if changes or additions are necessary. An additional premium or a credit may occur for any changes.

Premium should be remitted to our office in accordance with the payment schedule upon which we have agreed.

Sincerely,

Cheryl Norris
Field Underwriter

Enclosure

1712 Magnavox Way, P.O. Box 2338
Fort Wayne, IN 46801-2338
800-637-4757 Fax: 260-459-5866
www.kandkinsurance.com
California License #0334819

COV6

K&K INSURANCE SPECIALTY BENEFITS, INC. an affiliate of K&K Insurance Group, Inc.

AXIS

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):

O Pre-Kindergarten	**O** Elementary School	**O** Middle School
O High School	**O** Cafeteria	**O** Classroom Activities
O Interscholastic Sports	**O** Intramural Sports, *name of sport, if applicable:* _____	
O Club Sports	**O** Physical Education Class	**O** Other Activity (specify) _____
O During Practice	**O** During Play	**O** During Travel To or From the Event

   Nature of Your Participation:

O Student	**O** Volunteer	**O** Student/Manager
O Athletic Participant	**O** Cheerleader	**O** Band Member

   O Other (specify) _____
7. Transfer Student? **O** Yes **O** 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? **O** Yes **O** 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? **O** Yes **O** 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: _____

Any person who knowingly and with intent to defraud any insurance company or other person files 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 _____ Policyholder (School Official) Signature _____

IMPORTANT NOTICE

• 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 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 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 Maryland: Any person who knowingly of 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 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 and 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 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.

[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.

The First Health Network

HYGEIA

PHCS

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 O Yes O No

EMANCIPATED STUDENT: O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No

NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? O Yes O No	IS MOTHER DECEASED? O Yes O No
IS FATHER LEGALLY RESPONSIBLE? O Yes O No	IS MOTHER LEGALLY RESPONSIBLE? O Yes O No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No	EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O 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? O Yes O No	Do you have group medical insurance coverage through your employment? O Yes O No
If Yes, is it: O Individual O Family	If Yes, is it: O Individual O 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 COPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)	TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)
O PREFERRED PROVIDER ORGANIZATION (PPO)	O PREFERRED PROVIDER ORGANIZATION (PPO)
O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE	O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES
O OTHER (describe) _____	O 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 PROVISION 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 PROVISION 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: 0

POLICY RENEWAL

POLICYHOLDER: AXIS Accident and Health Group Insurance Trust

SUBSCRIBER: NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL

POLICY NUMBER: KAMV0000018089203

POLICY EFFECTIVE DATE: 08/01/2024

POLICY ANNIVERSARY: 08/01

STATE OF ISSUE: Rhode Island

This Amendment is attached to and made part of the Policy effective August 1, 2024 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.

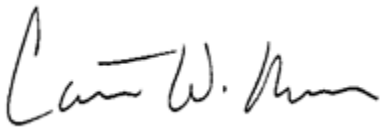
It is hereby understood and agreed the Policy is renewed for a period of one year, commencing on August 1, 2024 and ending August 31, 2025.

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