



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):

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

 Nature of Your Participation:

☐ Student	☐ Volunteer	☐ Student/Manager
☐ Athletic Participant	☐ Cheerleader	☐ Band Member
☐ 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: _____

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 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 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.



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 OVERAGE 26 AND NO LONGER DEPENDENT ON PARENT: ☐ Yes ☐ No

NAME OF INSURED: _____ POLICY NO: _____

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

POLICY AMENDMENT NO: 0

POLICY RENEWAL

POLICYHOLDER: LEBANON R-3 SCHOOL DISTRICT
POLICY NUMBER: KAMV0000018025204
POLICY EFFECTIVE DATE: July 1, 2025
POLICY ANNIVERSARY DATE: 07/01
STATE OF ISSUE: Missouri

This Amendment is attached to and made part of the Policy effective July 1, 2025 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 July 1, 2025 and ending August 31, 2026.

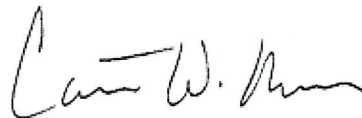
Renewal Premium: AS REPORTED

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

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 CERTIFICATE
AMENDMENT**

POLICY AMENDMENT NO: 0

POLICY RENEWAL

POLICYHOLDER: LEBANON R-3 SCHOOL DISTRICT

POLICY NUMBER: KAMV0000018025204

POLICY EFFECTIVE DATE: July 1, 2025

POLICY ANNIVERSARY DATE: 07/01

STATE OF ISSUE: Missouri

This Amendment is attached to and made part of the Certificate effective July 1, 2025 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.

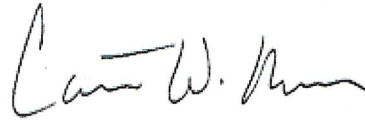
It is hereby understood and agreed the Policy is renewed for a period of one year, commencing on July 1, 2025 and ending August 31, 2026.

This Amendment expires concurrently with the Certificate 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

2025-2026 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
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
Inpatient Hospital Services		
Room & Board Expenses:	Up to \$150 per day/ Semi-private room rate	80% of Usual and Customary Charges/ Semi-private room rate
Miscellaneous Expenses		
Physician's Visits: (Limited to one visit per day)	\$600 maximum per day \$40 first day/\$25 each subsequent day	\$1,200 maximum per day \$60 first day/\$40 each subsequent day
Ambulatory Medical Center		
Emergency Room Treatment: (Treatment must be rendered within 72 hours from the time of the injury)	\$1,000 maximum \$150 maximum	\$1,200 maximum \$300 maximum
Surgery: (*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.)	\$1,000 maximum	\$1,200 maximum
Assistant Surgeon	100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)	100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)
Anesthesia and its Administration	100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)	100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)
Outpatient		
Outpatient Physician Visits: (Limited to one visit per day)	\$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:	\$50 maximum	\$300 maximum
Outpatient Physiotherapy: (Limited to one visit per day. Includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	\$30 first day/\$20 each subsequent day/ 5 days maximum	\$60 first day/\$40 each subsequent day/ 5 days maximum
Ambulance Services: (Air and Ground)	\$300 maximum	\$800 maximum
Medical Equipment Rental: (Includes Orthopedic devices)	\$75 maximum	\$140 maximum
Dental Services:	\$10,000 maximum per policy term	\$10,000 maximum per policy term
Prescription Drugs:	\$75 maximum	\$200 maximum
Consultant:	\$200 maximum	\$400 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids:	100% of Usual and Customary Charges	100% of Usual and Customary Charges

Expenses for the following are not covered: Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

This policy contains an excess provision. Benefits will not be paid under the Basic Accident Medical Expense for Covered Expenses to the extent that they are collectible under another Health Care Plan.

Details of these benefits may be found in the Master Policy on file at the School District. **NOTE:** This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control the payment of benefits.

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 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
24-Hour Accident 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
24-Hour Accident (Summer Only Coverage) 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
At-School Accident 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 or sports excluding High School Football. Travel to and from school sponsored and supervised activities or sports while in a school furnished or approved vehicle.	\$30.00	\$38.00
High School Football (Full Year) Play or practice of regularly scheduled football.	\$176.00	\$293.00
High School Football (Spring Only) 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
High School Football and At-School Accident (Covers all athletics)	\$206.00	\$331.00
High School Football and 24-Hour Accident (Covers all athletics)	\$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

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

 Cut out card and retain for your records

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.
 P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 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;

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 or any craft designed to fly above the Earth's surface, except as: (a) a farepaying passenger on a regularly scheduled commercial or charter airline;

6. travel in any Aircraft owned, leased 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. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of injuries sustained in a Covered Injury;
9. voluntary ingestion of narcotics, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

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 officers report, or similar items will be considered proof of the Insured Person's intoxication;

11. operating any type of vehicle or conveyance while under the influence of alcohol or narcotics 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;

12. 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;
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. Injuries compensable under Workers' Compensation law or any similar law;

15. 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;

16. 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 eligible 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. repair or replacement of existing artificial limbs, eyes and larynx;

5. 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 as specified above. 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 of Indemnity.

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	\$5,000
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 Thumb and Index Finger of the same Hand	\$2,500
Loss of all Four Fingers of the same Hand	\$2,500
Loss of all Toes of the same Foot	\$2,500
Exposure and Disappearance	Included

Enroll online for quicker service at www.StudentInsurance-kk.com
or complete and mail this form

Student Accident Enrollment Form (School Year 2025-2026)

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	☐ \$112.00	☐ \$165.00
24-HOUR, Summer Only	☐ \$39.00	☐ \$51.00
AT-SCHOOL	☐ \$30.00	☐ \$38.00
HIGH SCHOOL FOOTBALL COVERAGE, Full Year	☐ \$176.00	☐ \$293.00
HIGH SCHOOL FOOTBALL COVERAGE, Spring Only <i>For New Players</i>	☐ \$76.00	☐ \$124.00
HIGH SCHOOL FOOTBALL, and AT-SCHOOL <i>Covers all athletics</i>	☐ \$206.00	☐ \$331.00
HIGH SCHOOL FOOTBALL and 24-HOUR <i>Covers all athletics</i>	☐ \$288.00	☐ \$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.

Cobertura de accidentes para estudiantes 2025-2026

Prestada por: K&K Insurance Group, Inc. Teléfono: 855-742-3135

Recuerde visitar nuestro sitio web para una inscripción más rápida: www.studentinsurance-kk.com
Inscripción en línea—La Cobertura asegurada de accidentes puede adquirirse en cualquier momento del año.

COBERTURA SOLO ACCIDENTES: La Póliza ofrece beneficios por siniestros causados por una lesión cubierta hasta un Beneficio máximo de \$25,000 por lesión. Siempre que un Médico titulado y con licencia para ejercer inicie el tratamiento dentro de los 60 días siguientes a la fecha de la Lesión, se pagarán beneficios por los Gastos médicos cubiertos en los que se incurra durante las 52 semanas siguientes a la fecha de la Lesión hasta el Beneficio máximo por servicio, del modo que se indica a continuación.

PROGRAMA DE BENEFICIOS: Beneficios máximos pagados según lo especificado a continuación.

Compare y elija	Solo accidentes con opción baja	Solo accidentes con opción alta
Beneficio máximo:	\$25,000 (por lesión)	\$25,000 (por lesión)
Deducible:	\$0	\$0
Servicios hospitalarios para pacientes internos		
Gastos de alojamiento y comida:	Hasta \$150 por día/ Tarifa de habitación semiprivada	80% de los Gastos usuales y acostumbrados/ Tarifa de habitación semiprivada
Gastos varios		
Visitas médicas: (Limitadas a una visita por día)	Máximo de \$600 por día \$40 el primer día/\$25 por día posterior	Máximo de \$1,200 por día \$60 el primer día/\$40 por día posterior
Centro médico ambulatorio		
Tratamiento en sala de emergencias: (El tratamiento debe administrarse en las 72 horas siguientes al momento de la lesión)		
Cirugía: (*Se calcula la prestación: 100 % de los Gastos usuales y habituales correspondientes al primer procedimiento, 50 % de los Gastos usuales y habituales correspondientes al segundo procedimiento y 25 % de los Gastos usuales y habituales correspondientes a cada procedimiento adicional cuando se realice a través de diferentes incisiones/portales).	Máximo de \$1,000 Máximo de \$150 Máximo de \$1,000	Máximo de \$1,200 Máximo de \$300 Máximo de \$1,200
Cirujano asistente	100 % de los Gastos usuales y habituales (*La prestación se calcula: 20 % del máximo quirúrgico para la cirugía realizada del modo indicado anteriormente).	100 % de los Gastos usuales y habituales (*La prestación se calcula: 25 % del máximo quirúrgico para la cirugía realizada del modo indicado anteriormente).
Anestesia y su administración	100 % de los Gastos usuales y habituales (*La prestación se calcula: 20 % del máximo quirúrgico para la cirugía realizada del modo indicado anteriormente).	100 % de los Gastos usuales y habituales (*La prestación se calcula: 25 % del máximo quirúrgico para la cirugía realizada del modo indicado anteriormente).
Ambulatorio		
Visitas médicas ambulatorias: (Limitadas a una visita por día)	\$40 el primer día/\$25 por día posterior	\$60 el primer día/\$40 por día posterior
Radiografías ambulatorias:	Máximo de \$200	Máximo de \$600
Servicios ambulatorios de diagnóstico por imágenes:	Máximo de \$300	Máximo de \$600
Análisis de laboratorio ambulatorios:	Máximo de \$50	Máximo de \$300
Fisioterapia ambulatoria: (Limitada a una visita por día. Incluye acupuntura, microtermia, manipulación, diatermia, masajes, tratamiento con calor y tratamiento ultrasónico)	\$30 el primer día/\$20 por día posterior/ 5 días como máximo	\$60 el primer día/\$40 por día posterior/ 5 días como máximo
Servicios de ambulancia: (aérea y terrestre)	Máximo de \$300	Máximo de \$800
Alquiler de equipos médicos: (incluye dispositivos ortopédicos)	Máximo de \$75	Máximo de \$140
Servicios odontológicos:	Máximo de \$10,000 por el plazo de vigencia de la póliza	Máximo de \$10,000 por el plazo de vigencia de la póliza
Medicamentos recetados:	Máximo de \$75	Máximo de \$200
Especialista:	Máximo de \$200	Máximo de \$400
Cambio de anteojos, lentes de contacto o audífonos:	100 % de los Gastos usuales y habituales	100 % de los Gastos usuales y habituales

No se cubren los siguientes gastos: Dispositivos protésicos, trastornos mentales y nerviosos, atención médica domiciliaria, inyecciones.
Esta póliza contiene una provisión excesiva. Las prestaciones no se pagarán bajo el Gasto Médico Básico de Accidentes para los Gastos Cubiertos en la medida en que sean cobrables bajo otro Plan de Atención Médica.
Los detalles de estos beneficios se pueden encontrar en la Póliza Maestra archivada en el Distrito Escolar. **NOTA:** Este es un breve resumen de los beneficios y no un contrato. Se ha proporcionado una Póliza Maestra a su distrito escolar que contiene todas las disposiciones, limitaciones, exclusiones y calificaciones de los beneficios del seguro. La póliza Maestra es el contrato y regirá y controlará el pago de las prestaciones.

ESTA ES UNA PÓLIZA GENERAL DE SOLO ACCIDENTES.

EE. UU. AXIS Insurance Company suscribe la cobertura de seguro en los EE. UU. conforme al modelo de póliza colectiva con número de serie BACC-001-0909, et al. La cobertura está sujeta a exclusiones y limitaciones, y podría no estar disponible en todos los estados y jurisdicciones de los Estados Unidos. La disponibilidad de los productos y las características de diseño de los planes, incluidos los requisitos de elegibilidad, las descripciones de los beneficios y las exclusiones o limitaciones pueden variar en función de las leyes locales de los países o las leyes estatales de los EE. UU. En la póliza figura la totalidad de los términos y condiciones de la cobertura, incluidas las fechas de entrada en vigencia de la cobertura, los beneficios, las limitaciones y las exclusiones. La cantidad de beneficios proporcionados depende del plan seleccionado; la prima variará con la cantidad de beneficios seleccionados.
ESTE SEGURO NO PROPORCIONA COBERTURA MÉDICA MAYOR NI COBERTURA MÉDICA INTEGRAL Y NO HA SIDO DISEÑADO PARA SUSTITUIR UN SEGURO MÉDICO MAYOR. ADEMÁS, ESTE SEGURO NO CONSTITUYE BENEFICIOS ESENCIALES MÍNIMOS SEGÚN LO ESTABLECIDO EN LA LEY DE PROTECCIÓN AL PACIENTE Y ATENCIÓN MÉDICA ASEQUIBLE.

Elija su plan de cobertura: Pago único por la cobertura de accidentes

TEGA EN CUENTA PARA LOS PLANES DE COBERTURA QUE SE INDICAN A CONTINUACIÓN

Fecha de entrada en vigencia de la cobertura: La cobertura de una persona entra en vigencia en la fecha en la que la compañía reciba su formulario de inscripción en la cobertura de accidentes para estudiantes completado y la prima, o en la fecha de entrada en vigencia de la póliza emitida a favor de su centro o distrito escolar, lo que ocurra en último término.

Fecha de terminación de la cobertura: La cobertura finaliza en la fecha en que su cobertura cumpla doce meses de vigencia o en el primer día del año lectivo siguiente, lo que ocurra en primer término. Toda la cobertura cesará si el titular de póliza cancela la póliza o cuando la persona deje de ser una persona elegible de acuerdo con la definición que aparece más adelante. La terminación por cualquier motivo de la cobertura no afectará a una reclamación que se produzca con anterioridad a la finalización de la cobertura.

	Opción baja	Opción alta
Accidente 24 horas Las 24 horas. Antes, durante y después de la escuela. Fines de semana, vacaciones y todo el verano, incluida la escuela de verano. Deportes escolares y extraescolares, excepto fútbol americano de la escuela secundaria	\$112.00	\$165.00
Accidente 24 horas (cobertura solo verano) El verano comienza al día siguiente de terminar el año lectivo. El verano finaliza el primer día del año lectivo siguiente.	\$39.00	\$51.00
Accidente en la escuela Durante el período lectivo normal, en las instalaciones del centro escolar durante las horas escolares. Viajes directos e ininterrumpidos de ida y vuelta entre la casa y las clases programadas. Actividades o deportes escolares y con supervisión escolar, excepto fútbol americano de la escuela secundaria. Viajes de ida y vuelta entre actividades o deportes escolares y con supervisión escolar mientras se encuentre en un vehículo facilitado o aprobado por la escuela.	\$30.00	\$38.00
Fútbol americano de la escuela secundaria (todo el año) Jugar o practicar fútbol americano programado regularmente.	\$176.00	\$293.00
Fútbol americano de la escuela secundaria (solo primavera) Para nuevos jugadores que participen en el entrenamiento de primavera y que no estén ya asegurados con la Cobertura de fútbol americano. Las temporadas deportivas son definidas por la asociación deportiva de las escuelas secundarias de su estado.	\$76.00	\$124.00
Fútbol americano de la escuela secundaria y Accidentes en la escuela (Cubre todos los deportes)	\$206.00	\$331.00
Fútbol americano de la escuela secundaria y Accidente las 24 horas (Cubre todos los deportes)	\$288.00	\$458.00

Acerca de su cobertura

- PERSONAS ELEGIBLES: Los estudiantes del titular de póliza que se inscriban y realicen la contribución requerida para la prima correspondiente a la cobertura seleccionada son Personas elegibles según la póliza. Dependiendo de la cobertura seleccionada, la cobertura puede continuar después de la graduación y entre años lectivos, a menos que la persona se inscriba en un distrito escolar diferente.
- La Póliza maestra está registrada en el distrito escolar y es una póliza no renovable. La cobertura estudiantil seleccionada no es renovable y el estudiante debe volver a inscribirse en cada año lectivo.
- Esta es una póliza de beneficios limitados.
- FECHA DE ENTRADA EN VIGENCIA DE LA COBERTURA: El seguro entra en vigencia para un estudiante que se inscriba y realice la contribución requerida para la prima en la última de las siguientes fechas:
 - la Fecha de entrada en vigencia de la póliza;
 - la fecha en que la Compañía reciba el formulario de inscripción completado del estudiante y el pago requerido de la prima.

En ningún caso el seguro para la Persona elegible entrará en vigencia antes de la Fecha de entrada en vigencia de la póliza.

- FECHA DE TERMINACIÓN DE LA COBERTURA: La cobertura finalizará en la primera de las siguientes fechas: cuando la persona deje de ser una Persona elegible; cuando finalice el período de vigencia de 1 año de la cobertura; o en la fecha en la que finalice la póliza del Centro escolar. Toda la cobertura cesará si el titular de póliza cancela la póliza o cuando la persona deje de ser elegible. La terminación por cualquier motivo de la cobertura no afectará a una reclamación por un Accidente cubierto que se produzca con anterioridad a la fecha de terminación.
- INSCRIPCIÓN TARDÍA: La cobertura se puede adquirir en cualquier momento durante el año lectivo. No habrá reducción de la prima para ninguna persona que se inscriba de manera tardía durante el año.
- CANCELACIÓN: Su cobertura de la Póliza no se cancelará y, por tanto, no se podrán reembolsar las primas tras la aceptación de la Compañía.

Inscríbase en línea en:

www.StudentInsurance-kk.com

o por correo con el formulario de inscripción adjunto.

- Complete y separe el formulario de inscripción.
- Extienda un cheque o giro postal pagadero a AXIS Insurance Company. No envíe dinero en efectivo. La Compañía no se hace responsable de los pagos en efectivo.
- Escriba el nombre de su hijo/a en el cheque o giro postal.
- Envíe este formulario de inscripción con el pago por correo a:
**K&K Insurance Group,
P.O. Box 2338
Fort Wayne, IN 46801-2338**
- El cheque cobrado, la factura de la tarjeta de crédito o el talón del giro postal serán su comprobante y confirmación de pago.
- Guarde este folleto para consultas futuras. No se le enviarán pólizas individuales.

Política de privacidad

Sabemos que su privacidad es importante para usted y nos esforzamos por proteger la confidencialidad de su información personal no pública. No comunicamos a nadie información personal no pública sobre nuestros clientes o exclientes, excepto en la medida en que lo permita o exija la ley. Consideramos que contamos con las garantías físicas, electrónicas y procedimentales apropiadas para garantizar la seguridad de su información personal no pública.

Administrado por:

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

Recorte la tarjeta y guárdela como referencia

TARJETA DE SEGURO DEL ESTUDIANTE	
Nombre del estudiante _____ <i>Si se ha pagado una prima, el estudiante cuyo nombre figura más arriba ha sido asegurado a través de una Póliza emitida a favor de:</i>	
Distrito escolar: _____	
Cobertura solo accidentes: ☐ 24 HORAS ☐ 24-HORAS (Cobertura solo verano)	
☐ EN LA ESCUELA ☐ FÚTBOL AMERICANO ☐ FÚTBOL AMERICANO (Solo primavera)	
☐ AMPLIACIÓN DE LA COBERTURA ODONTOLÓGICA	
Pagado por cheque n.° _____	Monto pagado: _____ Fecha de pago: _____
Número de póliza _____	
Suscrita por: AXIS Insurance Company	
Preguntas en relación a siniestros: K&K Insurance Group, Inc.	
P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 800-237-2917	

EXCLUSIONES COMUNES

Además de los beneficios o exclusiones que sean específicos de la cobertura, no se pagarán beneficios por siniestros que se deriven directa o indirectamente, en su totalidad o en parte, de cualquiera de los siguientes sucesos, salvo cuando se ofrezca cobertura expresamente por su nombre en la sección Descripción de los beneficios o en la sección Condiciones de la cobertura:

1. lesión autoinfligida de manera intencional, suicidio o cualquier intento de hacerlo en su sano juicio;

2. cometer un delito o una agresión o intentar hacerlo;

3. efectuar disturbios o insurrección o participar activamente en ellos;

4. guerra o acto de guerra, declarada o no, o cualquier acto de guerra declarada o no, a menos que esta Póliza lo estipule específicamente;

5. vuelo en, embarque o alistamiento desde una aeronave o cualquier embarcación diseñada para volar por encima de la superficie terrestre, excepto en los siguientes casos: a) un pasajero que haya pagado el boleto correspondiente en una compañía aérea comercial o charter regularmente programada;

6. viajes en una Aeronave propiedad del titular de póliza o de una de sus subsidiarias o afiliadas, o alquilada, operada o controlada por cualquiera de ellos.. Se considerará que una Aeronave está "controlada" por el Titular de póliza si se puede utilizar la Aeronave del modo que desee el Titular de póliza durante más de 10 días consecutivos o durante más de 15 días a lo largo de un año;

7. enfermedad, dolencia, debilidad corporal o mental, infección bacteriana o viral, o su tratamiento médico o quirúrgico (incluida la exposición, Accidental o no, a agentes virales, bacterianos o químicos), independientemente de si el siniestro fue consecuencia directa o indirecta del tratamiento; excepto infecciones bacterianas causadas por un corte o herida externos Accidentales o por la Ingesta Accidental de alimentos contaminados;

8. tratamiento médico o quirúrgico, procedimiento de diagnóstico, administración de anestesia, o percañe o negligencia médica, incluida mala praxis, a menos que se produzca durante el tratamiento de lesiones constantes en una Lesión cubierta;
9. ingesta voluntaria de cualquier narcótico, veneno, gases o humos, a menos que sean recetados o tomados según las indicaciones de un médico y de conformidad con la dosis recetada;

10. ebriedad de la Persona asegurada. Se considerará de manera concluyente que la persona asegurada está ebria si el nivel en sangre excede la cantidad a la que se supone que una persona, conforme a las leyes de la localidad en la que ocurrió el accidente, está bajo la influencia de alcohol si conduce un vehículo motorizado, independientemente de si de hecho estaba conduciendo un vehículo motorizado; cuando se produce la lesión. El informe de una autopsia de un médico forense con licencia, el informe de un agente de policía o similar se considerará prueba de la ebriedad de la persona asegurada;

11. conducción de cualquier tipo de vehículo o Transporte bajo la influencia de alcohol o drogas, narcóticos u otro estupefaciente, incluidos medicamentos recetados para los que la Persona asegurada ha recibido una advertencia escrita sobre la imposibilidad de conducir un vehículo o Transporte mientras los toma. A los fines de esta exclusión, bajo la influencia de alcohol significa estar embriagado, según lo definen las leyes para vehículos motorizados del estado en el que ocurrió el perjuicio cubierto.

12. un Accidente si la Persona asegurada es el operador de un vehículo de motor y no posee una licencia válida de operador de vehículo de motor, a menos que: (a) la Persona asegurada sea titular de un permiso de aprendizaje válido y (b) la Persona asegurada reciba instrucciones de un instructor de manejo;
13. participar en actividades peligrosas, como los deportes de motos de nieve, vehículos todoterreno (todoterreno o vehículos con ruedas de un tipo similar), embarcaciones personales, caída libre, submarinismo, buceo a pulmón, ala delta, espeleología, bungee jumping, paracaidismo o escalada de montaña;

14. lesiones compensables conforme a la Ley de Indemnización Laboral u otra ley similar;

15. agravamiento, durante una Actividad cubierta, de una lesión que sufrió la Persona asegurada antes de participar en esa Actividad cubierta, a menos que la Compañía reciba una autorización médica por escrito del Médico de la Persona asegurada;

16. no se pagarán beneficios por servicios o tratamientos proporcionados por cualquier persona que:

a. sea empleada o contratada por el Titular de póliza;

b. viva en la casa de la Persona asegurada;

c. sea un familiar directo, incluida la pareja de hecho elegible, de la persona asegurada o del cónyuge de la persona asegurada; o

d. sea la Persona asegurada.

GASTOS EXCLUIDOS Los siguientes gastos no se considerarán Gastos necesarios por razones médicas cubiertos a menos que se ofrezca expresamente cobertura:

1. cirugía estética, excepto cirugía reconstructiva necesaria como consecuencia de una Lesión cubierta;

2. cualquier tratamiento, cirugía, tratamiento de salud o examen electivo o rutinario, incluido cualquier servicio, tratamiento de suministros que: (a) la Compañía considere experimental o experimental; y (b) no sea una práctica médica reconocida y generalmente aceptada en los Estados Unidos;
3. examen o recetas médicas, o compra, reparación o reemplazo, de sillas de ruedas, férulas, aparatos ortopédicos, férulas ortopédicas o dispositivos ortopédicos;

4. reparación o reemplazo de extremidades, ojos o laringe artificiales;

5. tratamiento de una lesión causada por una afección que la Persona asegurada sabía que existía en la fecha de un Accidente cubierto, a menos que la Compañía hubiera recibido del Médico de dicha persona un alta médica por escrito.

En ningún caso los pagos totales de la Compañía a favor de la Persona asegurada podrán superar el Máximo total correspondiente a todos los Beneficios médicos por accidentes indicado en el Programa de beneficios.
Otras exclusiones que se aplican a este Beneficio se encuentran en la sección Exclusiones comunes.

DEFINICIONES PARA SOLO ACCIDENTALES:

Lesión cubierta significa una lesión corporal Accidental:

1. que sufra una Persona asegurada como resultado directo de un Accidente cubierto involuntario y no previsto que sea en la parte externa del cuerpo y que se produzca mientras esté vigente la cobertura de la Póliza de la persona lesionada;

2. que se derive directa e independientemente de todas las demás causas de un Accidente cubierto; y

3. que se produzca durante la participación de dicha persona en una Actividad cubierta. La Lesión cubierta deberá ser causada por medios Accidentales. Se considerará una única lesión la totalidad de las lesiones sufridas por una Persona asegurada en cualquier Accidente cubierto, incluidas las afecciones relacionadas y los síntomas recurrentes de estas lesiones.

Accidente o accidental: significa un suceso precipitado, imprevisto, específico y repentino que ocurre por azar en un momento y lugar identificables mientras la Persona asegurada está cubierta por esta Póliza.

Gastos cubiertos: significa los gastos en los que efectivamente incurra una Persona asegurada, o se incurra en su nombre, por el tratamiento, los servicios y los suministros cubiertos por esta Póliza. Se considerará que se ha incurrido en un Gasto cubierto en la fecha en que se proporcionó u obtuvo el tratamiento, el servicio o el suministro que haya dado lugar al gasto o al cargo.

Necesarios por razones médicas: significa servicios médicos que:
1. sean esenciales para el diagnóstico, tratamiento o cuidado de la Lesión cubierta para el que se receten o practiquen;
2. cumplan con los estándares generalmente aceptados de la práctica médica; y
3. sean indicados por un Médico y practicados bajo su atención, supervisión o dirección.

BENEFICIOS POR MUTILACIÓN O MUERTE ACCIDENTAL:

El Siniestro cubierto deberá producirse dentro de los 365 días posteriores al Accidente cubierto. No se pagará más que el límite total de \$500,000 por todos los perjuicios, accidentes y lesiones cubiertos que sufran todas las personas aseguradas como resultado de cualquier accidente cubierto que se produzca, conforme a cualquiera de las condiciones de la cobertura, según se especificó anteriormente. Este Límite total solo se pagará una vez. En caso de que resulte aplicable más de una Condición de la cobertura, pagaremos el mayor de los montos. Si este monto no permite que se paguen a todas las personas aseguradas los montos indicados por esta póliza, el monto a pagar será la parte proporcional del perjuicio de la persona asegurada con respecto al total de todos los perjuicios, multiplicada por el límite total de compensación.

SINIESTRO CUBIERTO

Muerte	\$10,000
Pérdida de dos o más manos o pies	\$10,000
Pérdida de la vista en ambos ojos	\$10,000
Pérdida del habla y la audición (en ambos oídos)	\$10,000
Pérdida de una mano o pie y de la vista en un ojo	\$5,000
Pérdida de una mano o pie	\$5,000
Pérdida de la vista en un ojo	\$5,000
Pérdida del habla	\$5,000
Pérdida de la audición (en ambos oídos)	\$5,000
Pérdida de los dedos pulgar e índice de la misma mano	\$2,500
Pérdida de cuatro dedos de la misma mano	\$2,500
Pérdida de todos los dedos del mismo pie	\$2,500
Exposición y desaparición	Incluido

MONTO DEL BENEFICIO

\$10,000
\$10,000
\$10,000
\$10,000
\$5,000
\$5,000
\$5,000
\$5,000
\$5,000
\$2,500
\$2,500
\$2,500
Incluido

Inscríbase en línea para recibir un servicio más rápido en **www.StudentInsurance-kk.com**

o complete y envíe este formulario por correo postal

Formulario de inscripción en la cobertura de accidentes para estudiantes (año lectivo 2025-2026)

Apellido del estudiante: _____
Nombre del estudiante: _____
Segundo nombre del estudiante: _____ Fecha de nacimiento: _____
Dirección: _____
Ciudad: _____ Estado: _____ Código postal: _____
Nombre del distrito escolar (obligatorio): _____
Nombre del centro escolar: _____
Nivel de grado: ☐ Prekinder/Preprimaria ☐ Kinder/Escuela primaria ☐ Escuela intermedia ☐ Escuela secundaria/Superior
Firma del padre/madre o tutor: _____
Fecha: _____ Dirección de correo electrónico: _____ Número de teléfono: _____

Opciones de planes de seguro para estudiantes — Marque su selección:

Planes de cobertura solo accidentes

	Opción baja	Opción alta
24 HORAS	☐ \$112.00	☐ \$165.00
24 HORAS, solo verano	☐ \$39.00	☐ \$51.00
EN LA ESCUELA	☐ \$30.00	☐ \$38.00
COBERTURA DE FÚTBOL AMERICANO DE ESCUELA SECUNDARIA, todo el año	☐ \$176.00	☐ \$293.00
COBERTURA DE FÚTBOL AMERICANO DE ESCUELA SECUNDARIA, solo primavera <i>Para jugadores nuevos</i>	☐ \$76.00	☐ \$124.00
FÚTBOL AMERICANO DE ESCUELA SECUNDARIA y EN LA ESCUELA <i>Cubre todos los deportes</i>	☐ \$206.00	☐ \$331.00
FÚTBOL AMERICANO DE ESCUELA SECUNDARIA y 24 HORAS <i>Cubre todos los deportes</i>	☐ \$288.00	☐ \$458.00

DISCLOSURE - THE ATTACHED ENGLISH LANGUAGE VERSION OF THIS DOCUMENT IS THE OFFICIAL VERSION AND CONTROLS IN THE EVENT OF A DISPUTE OR COMPLAINT. THE SPANISH VERSION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

AVISO - LA VERSIÓN EN INGLÉS QUE SE ADJUNTA CON ESTE DOCUMENTO ES LA VERSIÓN OFICIAL Y PREVALECE EN CASO DE CONFLICTO O RECLAMACIÓN. LA VERSIÓN EN ESPAÑOL SE PROPORCIONA CON FINES EXCLUSIVAMENTE INFORMATIVOS.

Adjunte el cheque por el importe total pagadero a: **AXIS INSURANCE COMPANY**. Se aceptan cheques, giros postales o tarjetas de crédito.

NO ENVÍE DINERO EN EFECTIVO

MONTO TOTAL ENVIADO: \$ _____

Consulte el AVISO IMPORTANTE - ADVERTENCIA DE FRAUDE en la página siguiente.

Envíe este formulario completado con el pago a: **K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338**

Complete esta sección solo si desea pagar con tarjeta de crédito

Nombre completo tal como aparezca en la tarjeta

Nombre: _____ Inicial del segundo nombre: _____ Apellido: _____

Dirección de facturación (si es distinta de la anterior)

Calle N.º _____ Dirección _____ N.º de apto. _____

Ciudad: _____ Estado: _____ Código postal: _____

Número de tarjeta: Fecha de vencimiento: Mes: Año:

Firma del titular de la tarjeta: _____

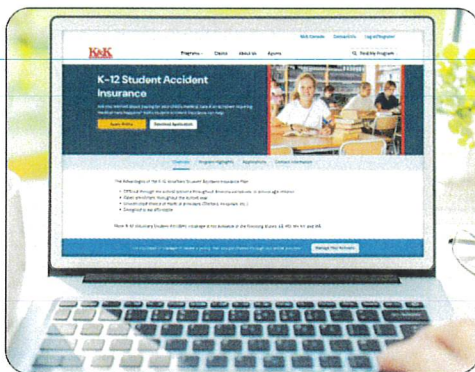
La Compañía no emite reembolsos ni se hace responsable de los pagos en efectivo. (Si el banco rechaza el cheque o la tarjeta de crédito por cualquier motivo, se invalidará el seguro).

AVISO IMPORTANTE - ADVERTENCIA DE FRAUDE

- **En general, y de manera específica para los residentes de Arkansas, Illinois, Louisiana, Rhode Island y Virginia Occidental:** Toda persona que intencionadamente presente un reclamo falso o fraudulento exigiendo el pago de un perjuicio o beneficio o que intencionadamente presente información falsa en una solicitud de seguro será culpable de un delito y podrá estar sujeta a multas y encarcelamiento en prisión.
- **Para residentes de Alabama:** Toda persona que intencionadamente presente un reclamo falso o fraudulento exigiendo el pago de un perjuicio o beneficio o que intencionadamente presente información falsa en una solicitud de seguro será culpable de un delito y podrá estar sujeta a indemnizaciones, multas y encarcelamiento en prisión, o a cualquier combinación de las penalidades anteriores.
- **Para residentes de California:** Para su protección, las leyes de California exigen que se incluya lo siguiente en este formulario. Toda persona que intencionadamente presente información falsa o fraudulenta para obtener o modificar la cobertura de un seguro o presentar un reclamo para el pago de un siniestro es culpable de un delito y podrá estar sujeta a multas y encarcelamiento en una prisión estatal.
- **Para residentes de Colorado:** Es ilegal proporcionar intencionadamente información o datos falsos, incompletos o engañosos a una compañía de seguros con el fin de defraudar o intentar defraudar a la compañía. Las sanciones pueden incluir encarcelamiento, multas, negación de seguro e indemnización por daños y perjuicios de responsabilidad civil. Toda compañía de seguros o agente de una compañía de seguros que a sabiendas proporcione información o datos falsos, incompletos o engañosos a un asegurado o reclamante con el fin de defraudar o intentar defraudar al asegurado o reclamante con respecto a un pago del seguro o indemnización pagadera del producto del seguro será denunciado ante la División de Seguros de Colorado dentro del Departamento de Agencias Reguladoras.
- **Para residentes del Distrito de Columbia:** **ADVERTENCIA:** Constituye delito proporcionar información falsa o engañosa a una aseguradora con el fin de defraudar a la aseguradora o a cualquier otra persona. Las sanciones incluyen encarcelamiento o multas. Además, una aseguradora podrá denegar beneficios de seguro si el solicitante proporcionó información falsa estrechamente relacionada con un siniestro.
- **Para residentes de Florida:** Toda persona que intencionadamente, y buscando perjudicar, defraudar o engañar a cualquier aseguradora, presente una notificación de siniestro o una solicitud que contenga información falsa, incompleta o engañosa será culpable de un delito grave de tercer grado.
- **Para residentes de Kentucky:** Toda persona que intencionadamente, y buscando defraudar a cualquier compañía de seguros, presente una solicitud de seguro que contenga información esencialmente falsa u oculte, con el fin de engañar, información relacionada con cualquier hecho importante relacionado incurrirá en un acto fraudulento en contra del seguro, constitutivo de delito.
- **Para residentes de Maine, Tennessee y Washington:** Constituye delito proporcionar intencionadamente información falsa, incompleta o engañosa a una compañía de seguros con el fin de defraudar a la compañía. Las sanciones incluyen encarcelamiento, multas y negación de beneficios del seguro.
- **Para residentes de Maryland:** Toda persona que intencionada o dolosamente presente un reclamo falso o fraudulento exigiendo el pago de un perjuicio o beneficio, o que intencionada o dolosamente presente información falsa en una solicitud de seguro será culpable de un delito y podrá estar sujeta a multas y encarcelamiento en prisión.
- **Para residentes de Nuevo Hampshire:** Toda persona que, con el propósito de perjudicar, defraudar o engañar a cualquier compañía de seguros, presente una notificación de siniestro que contenga información falsa, incompleta o engañosa está sujeta a enjuiciamiento y castigo por fraude contra el seguro, según lo dispuesto en RSA 638:20.
- **Para residentes de Nueva Jersey:** Toda persona que incluya información falsa o engañosa en una solicitud de una póliza de seguro estará sujeta a sanciones penales y civiles.
- **Para residentes de Nuevo México:** TODA PERSONA QUE INTENCIONADAMENTE PRESENTE UN RECLAMO FALSO O FRAUDULENTO EXIGIENDO EL PAGO DE UN PERJUICIO O BENEFICIO, O QUE INTENCIONADAMENTE PRESENTE INFORMACIÓN FALSA EN UNA SOLICITUD DE SEGURO SERÁ CULPABLE DE UN DELITO Y PODRÁ ESTAR SUJETA A MULTAS CIVILES Y SANCIONES PENALES.
- **Para residentes de Nueva York:** Toda persona que intencionadamente, y buscando defraudar a cualquier compañía de seguros o a otra persona, presente una solicitud de seguro o una notificación de siniestro que contenga información esencialmente falsa u oculte, con el fin de engañar, información relacionada con cualquier hecho importante relacionado incurrirá en un acto fraudulento en contra del seguro, constitutivo de delito, y también estará sujeta a una sanción civil que no superará los cinco mil dólares y el valor declarado del siniestro por cada uno de los ilícitos.
- **Para residentes de Ohio:** Toda persona que, buscando defraudar o sabiendo que está facilitando un fraude contra una aseguradora, presente una solicitud o una notificación de siniestro que contenga una declaración falsa o engañosa será culpable de fraude contra el seguro.
- **Para residentes de Oklahoma:** **ADVERTENCIA:** Toda persona que intencionadamente, y buscando perjudicar, defraudar o engañar a cualquier aseguradora, presente una notificación de siniestro reclamando el producto de una póliza de seguro que contenga información falsa, incompleta o engañosa será culpable de un delito grave.
- **Para residentes de Oregón:** Toda persona que intencionada y dolosamente presente un reclamo falso o fraudulento exigiendo el pago de un perjuicio o beneficio, o que intencionada o dolosamente presente información falsa en una solicitud de seguro podrá ser culpable de un delito y podrá estar sujeta a multas y encarcelamiento en prisión.
- **Para residentes de Pensilvania:** Toda persona que intencionadamente, y buscando defraudar a cualquier compañía de seguros, presente una solicitud de seguro o notificación de siniestro que contenga información esencialmente falsa u oculte, con el fin de engañar, información relacionada con cualquier hecho importante relacionado incurrirá en un acto fraudulento en contra del seguro, constitutivo de delito, y dicha persona quedará sujeta a sanciones penales y civiles.
- **Para residentes de Texas:** Toda persona que intencionadamente presente un reclamo falso o fraudulento exigiendo el pago de un perjuicio será culpable de un delito y podrá estar sujeta a multas y encarcelamiento en una prisión estatal.
- **Para residentes de Virginia:** Toda persona que, buscando defraudar o sabiendo que está facilitando un fraude contra una aseguradora, presente una solicitud o una declaración falsa o engañosa podrá haber incurrido en una violación de la ley del estado.

K-12 Student Accident Insurance

Apply Online today



Are you worried about paying for your child's medical care if an accident requiring medical care happens? K&K's student accident insurance can help.

¿Le preocupa tener que pagar la atención médica de su hijo si ocurre un accidente? El seguro contra accidentes para estudiantes de K&K puede ayudarlo.

K-12 Accident Plans available through your school:

- At-School Accident Only
- 24-Hour Accident Only
- Extended Dental
- Football

Planes de cobertura en caso de accidente para K-12 disponibles a través de su escuela:

- Sólo accidentes en la escuela
- Sólo accidentes, 24 horas
- Dental extendido
- Fútbol

How to Enroll Online

Enrolling online is easy and should take only a few minutes. Go to **www.studentinsurance-kk.com** and click the "Apply Online" button.

1. Start by telling us the name of the school district and state where your child attends school. Enter the first few letters of the school/district name.
2. We'll request each student's name and grade level.
3. You'll see the available plans and their rates. Select your coverage and continue to the next step.
4. We'll request information about you, like your name and email address.
5. Next, you'll enter information about the child or children to be covered.
6. Enter your credit card or eCheck payment information.
7. Finally, print out a copy of the confirmation for your records.

Cómo inscribirse en línea

Enscribirse en línea es fácil y sólo le tomará unos pocos minutos. Visite **www.studentinsurance-kk.com** y haga clic en el botón "Apply Online" ("Aplicar en línea").

1. Comience por decirnos el nombre del distrito escolar y el estado en el que su hijo(a) va a la escuela.
2. Solicitaremos el nombre y el grado de cada uno de los estudiantes.
3. Verá los planes disponibles y sus tarifas. Seleccione su cobertura y continúe con el siguiente paso.
4. Le solicitaremos información sobre usted, como su nombre y dirección de correo electrónico.
5. Después, ingresará la información acerca del niño o niños que recibirá(n) cobertura.
6. Ingrese la información de pago de su tarjeta de crédito o eCheck.
7. Finalmente, imprima una copia de la confirmación para sus registros.

For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the policy may be continued in force, please refer to **www.studentinsurance-kk.com**. Student is able to purchase the coverage only if his/her school district is a policyholder with the insurance company.



Para obtener más detalles sobre la cobertura, incluidos costos, beneficios, exclusiones y reducciones o limitaciones y los términos en virtud de los cuales esta póliza podría continuar en vigencia, consulte **www.studentinsurance-kk.com**. Los estudiantes pueden comprar la cobertura únicamente si su distrito escolar es titular de una póliza con la compañía de seguros.

1709_WV_WY (10/24_K12)

www.studentinsurance-kk.com



Add **www.studentinsurance-kk.com** to your school's website

Adding a link to your school's website may make it easier for parents to enroll their students in your endorsed student insurance plan. Our website, www.studentinsurance-kk.com, provides easy online enrollment. You can choose from simply adding a simple text link or something more descriptive

Suggested samples for adding www.StudentInsurance-KK.com to your school/district website:

*As you select a listing from the samples below, please set up your choice with a hyperlink to
<http://www.studentinsurance-kk.com>*

1. Simple Text Options (with hyperlink)

example a. **Enroll in Student Insurance Here**

example b. **Quote/Buy Student Insurance Online**

2. Descriptive Text Options (with hyperlinks)

example a. **Student Accident Insurance** and the following paragraph either directly below or as a popup option. The paragraph also contains 2 hyperlink options (in bold).

*Our school/district has selected the **Student Insurance Plan** from K&K Insurance Group to make reliable coverage available to parents. If you don't have other insurance, this plan may be a resource to consider. Additionally, even if you have other coverage, this plan can help fill expensive "gaps" caused by deductible and co-pays. Coverage may be purchased at any time during the school year by visiting **www.studentinsurance-kk.com**.*

example b. **Student Accident Insurance** and the following paragraph either directly below or as a popup option. The paragraph also contains 1 hyperlink option (in bold).

*Our school/district has selected the Student Insurance Plan from K&K Insurance to make reliable coverage available to parents. Coverage may be purchased at any time during the school year by visiting **www.studentinsurance-kk.com**.*

If you do not have the ability to add links to your website, simply pass this sheet along to the technology team responsible for your school/district website. You may encourage individual schools to add this to their own sites as well. If you need additional assistance, please send an email to info@studentinsurance-kk.com.

