

Student Accident Insurance Comprehensive Group - No Deductible Plan Policy GA-2200Ed.11-16

SUMMARY OF GROUP COVERAGE

The school purchased a group insurance policy that will provide benefits for accidental bodily injury incurred while the student is:

- a. attending regular school sessions,
- b. participating in or attending school-sponsored and supervised extracurricular activities,
- c. practicing or competing in school-sponsored and supervised interscholastic sports, and
- d. traveling directly to and from school for regular school session; and while traveling to and from school sponsored and supervised extracurricular activities or interscholastic sports in school-provided transportation.

OTHER COVERAGE OPTION TO PURCHASE

PARENTS: Now you may extend this valuable school-time protection by purchasing 24-Hour Accident coverage:

24-HOUR ACCIDENT COVERAGE (FULL-TIME) - Covers your student 24-hours a day, any time or anywhere, until school starts next year. Provides benefits for doctor, hospital and dental expenses arising from an accidental injury.

HOW TO ENROLL: Complete the attached enrollment form, enclose with your premium payment and mail to: (DO NOT SEND TO SCHOOL)

Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082

The Medical Benefits and Exclusions below apply to the summary and coverage option above

MEDICAL BENEFITS

When injury covered by the Policy results in treatment by a licensed physician within 60 days from the date of injury, the Company will pay the Usual and Customary (U&C) expenses incurred for covered services as listed below, for expenses actually incurred within one year from the date of injury up to a maximum benefit of **\$25,000 per injury**. Unless stated otherwise, all amounts listed below are per injury.

This insurance plan is secondary to all other valid coverage. A claim must be filed with other valid coverage first! This plan does not cover penalties imposed for failure to use providers preferred or designated by the primary coverage.

PHYSICIAN'S SERVICES

- a) **Surgical Care**
 - **Surgeon** - U&C; only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession
 - **Assistant Surgeon and Anesthesia Services** - 25% of the surgeon's allowance
- b) **Nonsurgical Care** (includes physiotherapy, 1 visit per day; other than concussion) - U&C, up to \$100 per visit, maximum 10 visits
- c) **Nonsurgical Care for Concussion** (treatment for concussion) - U&C, up to \$1,000

HOSPITAL CARE

- a) **Inpatient Care**
 - **Hospital Semi-private Room** - U&C
 - **Hospital Miscellaneous Services** (includes charges for registered nurse) - U&C
- b) **Outpatient Care**
 - **Facility Charges for Day Surgery and Emergency Room** (does not include physiotherapy) - U&C
 - **Physiotherapy** - U&C, up to \$1,000

Note: Benefits for hospital miscellaneous and outpatient care charges are limited to services not scheduled under Medical Benefits.

RADIOLOGY SERVICES (includes x-ray, MRI, CT Scan, bone scan, and charges for reading) - U&C

DENTAL TREATMENT (in lieu of all other medical benefits, for sound and natural teeth) - U&C, up to \$5,000

AMBULANCE SERVICES (benefit for ground ambulance only) - U&C

ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing; includes charges for durable medical equipment) - U&C, up to \$300

PRESCRIPTION DRUGS (take home) - U&C, up to \$300

REPLACEMENT EYEGLASSES, CONTACT LENSES, HEARING AIDS (when medical treatment is required for covered injury) - U&C, up to \$300

LABORATORY SERVICES (Outpatient) - U&C, up to \$300

SHOTS AND INJECTIONS (Outpatient, in lieu of physician non-surgical care) - U&C, up to \$300

MOTOR VEHICLE INJURY - Same as any Injury, up to \$2,000

The policy contains a provision limiting coverage to usual and customary charges. This limitation may result in additional out-of-pocket expenses for the insured.

ACCIDENTAL DEATH AND DISMEMBERMENT

When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable.

Loss of Life\$2,500 Single Dismemberment\$2,500 Double Dismemberment\$10,000

L-5676(2026)

(12)

**STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER MN 55082-0196**



IS YOUR CHILD PROTECTED?

PROOF OF CLAIM

There is a timely filing period of one year and ninety days. Do not wait to send information as this may result in claim denial.

Email, Fax or Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

CLAIM PROCEDURE:

1. A school official must complete and sign PART A*.
2. The student's parent or guardian must complete PART B.
3. See Page 2 for important claim procedures.

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
School Address _____ (City) _____ (State) _____ (Zip) _____
2. Name of Student _____ Grade _____
3. Date of Injury _____ ☐ AM ☐ PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:
- | INTERSCHOLASTIC SPORTS | | NON-INTERSCHOLASTIC SPORTS | |
|-----------------------------------|---|---|--|
| ☐ Practice | ☐ Travel to/from Sport | ☐ Travel to/from School | ☐ Non-school activity |
| ☐ Game | | ☐ In classroom | ☐ Physical Education |
| What Sport? _____ | | ☐ Other - Activity _____ | |
| | | ☐ On school grounds | |
6. Part of the body injured _____ ☐ Left ☐ Right
7. Describe in detail how and where the injury occurred _____

- Reported by _____ (Signature of School Official) _____ (Title) _____ Date(mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____
Date (mm/dd/yyyy) _____
- Students Social Security # _____ - _____ - _____
- Parents Name _____ Relationship to Insured _____
- Mailing Address _____ (City) _____ (State) _____ (Zip) _____
(Street, Route, Box, Apt., or Lot #)
2. Home phone number _____
3. Father's Occupation _____ Employer _____
Mother's Occupation _____ Employer _____
4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No
- Name of Insurance Company _____
- ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ Tricare ☐ None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I am indicating my intent to sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ Date (mm/dd/yyyy) _____ (Print Name of Student/Patient) _____ (Signature of Parent or Guardian)