Dinuba Unified School District

ADMINISTRATIVE OFFICE: 1327 E. El Monte Way, Dinuba, California 93618
Tel. (559) 595-7200 • FAX (559) 591-3334

STUDENT ACCIDENT INSURANCE / HEALTH INSURANCE
2026-27 School Year

Dear Parents:

The Dinuba Unified School District School District **does not provide medical, accident or dental insurance** for pupils injured on school premises or through school activities. In accordance with Education Code Section 49472, the District is making available a low-cost medical/dental accident insurance program.

Accident Only Plans

The purpose of these plans is to provide assistance at a minimum cost to meet some of the expenses for accidental injury. The plans pay the first $500.00 in benefits in addition to other insurance, which can help you meet your primary insurance deductibles and/or co-payments.

The plan costs are in the chart below. Please visit your Childs' School Office to obtain a detailed brochure/application, or you may obtain one and sign up online at www.peinsurance.com (click on Products, then Student Insurance). Please read the Student Benefits Plan Brochure to select the plan that best meets your needs.

All Plans Are A **ONE TIME ANNUAL** Payment

Options	*Low*	*High*
At School Plan		
Grades P-8	$11.00	$25.00
Grades 9-12	$24.00	$54.00
24-Hr-a-Day Plan		
Grades P-8	$75.00	$161.00
Grades 9-12	$92.00	$192.00
Optional Tackle Football Coverage		
Grade 9	$36.00	$80.00
Grades 10-12	$84.00	$177.00

Please see brochure for complete plan details

Health Insurance Plans

Pacific Educators can now assist people in applying for health insurance plans that meet the guidelines of the **Affordable Care Act** and help you avoid potential tax penalties. These penalties will be increasing each year from 2014-on. Some may **qualify for tax savings and government assistance**. We will be happy to help you get all the potential assistance/subsidies you are eligible for. Please call the number below or visit our website at www.peinsurance.com click 'products' and then 'health insurance'.

Since the district does NOT provide medical/dental accident insurance, we urge that serious consideration be given to these programs. If you have further questions, please call Pacific Educators, Inc., at (800) 722-3365 or (714) 639-0962.

Marti Kochevar, M. Ed.
Superintendent

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT CLAIM FORM

- Parts 1 and 3 of the claim form must be completed and signed by a parent or guardian (or the student, if an adult). Part 2 of the claim form must be completed and signed by a School official.
  Also, the *HIPAA Authorization To Permit Use and Disclosure of Health Information* must be completed and signed.

- Your School Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Policy for the "Initial Treatment Period."

- PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED **WITHIN 90 DAYS OF THE ACCIDENT**. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED **WITHIN 90 DAYS OF TREATMENT**.

- Please attach itemized bills to the claim form. A balance due bill from your provider is not sufficient.
  An itemized bill is a statement that indicates:
  1) **The date(s) of treatment,**
  2) **The type(s) of service,**
  3) **The diagnosis,**
  4) **The medical provider's name and address,**
  5) **And the individual charge for each expense**.

- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.

- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of
- Benefits") statements (if applicable) to: Guarantee Trust Life Insurance Company
  PO Box 1144
  Glenview, IL 60025

- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please notate this on the bills or in Part 1 of the claim form.

- Only one completed claim form per accident is required to be sent to us. Additional related bills or follow-up treatment to be sent to us should indicate the student's name, school name and/or policy number and date of accident.

- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please note that your claim will result in a processing delay as the result of not providing us with the following: the completed claim form, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at 800-338-7452.



GTL | GUARANTEE TRUST LIFE

Mail claims to:
PO Box 1144, Glenview, IL 60025
Or fax to: 847-699-1048
Or e-mail to: Claims@gtlic.com
For Customer Service, please call: 800-338-7452

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

SPECIAL RISK ACCIDENT CLAIM FORM

PART 1 - ASSIGNMENT OF BENEFITS:

Dr: _____	Hosp: _____	Other: _____
Addr: _____	Addr: _____	Addr: _____
_____	_____	_____
_____	_____	_____
City, State Zip	City, State Zip	City, State Zip

I hereby authorize Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____
Claimant - if an ADULT

PART 2 - SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT:

(PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. Claimant's FULL NAME _____ Alternate Name _____ Date of Birth _____ Grade ___
2. Claimant's Address: Street or RFD _____ City _____ State ___ Zip _____
3. Date of Accident _____ 20___ Hour _____ ☐ AM ☐ PM
4. Description of Accident: **(A)** How and where did it occur? _____
_____ (if more space needed, attach separate sheet)
(B) Nature of Injury _____
5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ ☐ Intramural ☐ Interscholastic ☐ Other
6. **(A)** On date of accident what time did school start for this student? _____ ☐ AM ☐ PM
(B) What time was student dismissed from school? _____ ☐ AM ☐ PM
7. Has a previous claim been filed for this accident? ☐ Yes ☐ No
8. **(A)** Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? ☐ Yes ☐ No
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: ☐ Elementary ☐ Jr. High ☐ High ☐ Other

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PART 3 - PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY? ☐ Yes ☐ No

IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:

Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: _____ _____

Employer's Name: _____

Employer's Address: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: _____ **SIGNATURE** _____

Guarantee Trust Life Insurance Company, PO Box 1144, Glenview, Illinois 60025
800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy / Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to GTL, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent GTL has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that GTL may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(Print Please) Name of Patient	Date of Birth
Signature of Patient	Date
(Please Print) Name of Authorized Representative, or Next of Kin	
Relationship of Authorized Representative or Next of Kin to Patient	
Signature of Authorized Representative or Next of Kin	Date



Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

General Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, 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.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida - Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky - A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FILES AND CRIMINAL PENALTIES.

Ohio and Oregon - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

Tennessee, Virginia and Washington State - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Texas - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pacific Educators
Insurance Services

- Please note that there are four pages to the brochure (not including this one)
- You may apply online with a credit card here https://www.peinsurance.com/signup/ OR:
- If you would like to apply with a paper application, the third page below is an actual application that you can print and complete by hand, **or you may complete on computer and print**. DO NOT SEND CASH. Make check or money order payable to Pacific Educators and mail to:

Pacific Educators
2808 E. Katella Ave., Suite 101
Orange, CA 92867

- The last page is a **FREE Prescription Drug Card Program** you can print and take to a Pharmacy to help anyone lower their prescription drug costs.
- If you have any questions, please do not hesitate to contact us directly (800) 722-3365 or email at applications@peinsurance.com

2026-2027 STUDENT ACCIDENT INSURANCE PLANS

WE RECOMMEND 24-HOUR-A-DAY COVERAGE

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital charges.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL) or its representative (but not prior to the opening day of school).
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

OPTIONAL FOOTBALL COVERAGE BEGINS ON THE DATE OF PREMIUM RECEIPT BY GTL, ITS REPRESENTATIVES OR SCHOOL OFFICIALS, BUT NOT PRIOR TO THE FIRST OFFICIAL DATE OF PRACTICE; AND CONTINUES THROUGH THE DATE OF THE LAST OFFICIAL GAME OF THE CURRENT SEASON INCLUDING PLAYOFFS.

To file a claim: Report accidents to the school official. Simplified forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Completed proof of loss and accumulated bills must be received by GTL within 90 days.

24-HOUR-A-DAY ACCIDENT COVERAGE

24-Hour-A-Day Protection for each Covered Accident

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

✎ At home ✎ At play ✎ At school ✎ On vacation ✎ Scouting, camping etc. ✎ During covered travel

✎ While engaged in sports, except those specifically excluded or for which optional coverage is required*

***See OPTIONS for available optional sports coverage, if any.**

SCHOOL-TIME ACCIDENT COVERAGE

Helps protect your child while attending regular school sessions. Includes coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

TERMINATION OF POLICY/CERTIFICATE OF COVERAGE: The Policy is issued for the agreed upon term of coverage and is non-renewable. Coverage will terminate at the earlier of: (1) the date the Policy terminates; or (2) the date the Insured ceases to be a member of the Policyholder's sports teams; or (3) the last day of regularly scheduled sports activity; or (4) the date the Insured ceases to be an Eligible Person; or (5) the end of the period for which any applicable premium has been paid. We have the right to terminate the coverage of any Insured who submits a fraudulent claim under the Policy.

This is an illustration of your child's benefits. Please keep for your records. This is not a contract. The Master Policy is on file with your school.

Blanket Accident insurance is issued under Policy Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. The policy has exclusions, limitations, reductions of benefits, and conditions of eligibility and termination. Subject to state availability and variability. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage, please contact the agent administering the program.

What's Covered? *Up to* $50,000.00 as described under Benefits Per Injury for:

■ Accidents occurring while coverage is in force. ■ Loss from accidental bodily Injury resulting directly and independently of all other causes. ■ Covered medical charges which begin within 120 days of the Accident and are incurred within 52 weeks of the date of first medical treatment.

Your school district does not carry medical or dental insurance for your child should he/she be injured on school premises while under school grounds jurisdiction, or through school sponsored activities. However it does make this plan available to you, for your consideration.

Esto es para avisarle que su Districto de la Escuela no tiene aseguranza medica ni dental para su nino/nina si se lastima en el terreno de la esquela aunque haiga supervisor en las actividades. Pero se puede tener un plan para su consideracion. Este plan de aseguranza es voluntario. Usted debe saber que la ley del estado requiere cualquier estudiente que participe en deportes escolares debe tener aseguranza adecuada para medico antes de paticipar en deportes.

BENEFITS PER INJURY - PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW	HIGH OPTION	LOW OPTION
HOSPITAL & GENERAL NURSING CARE - Room and board per day, semi-private room rate	100% of R&C*	$300
- Intensive Care, per day	$1,200	$600
INPATIENT AND OUTPATIENT HOSPITAL MISCELLANEOUS CHARGES	$3,000	$1,500
HOSPITAL EMERGENCY CARE, excluding professional charges	$300	$150
DOCTOR'S CHARGES FOR SURGERY, limited to a maximum of	$5,000	$3,000
ADMINISTRATION OF ANESTHESIA	100% of R&C*	
ASSISTANT SURGEON CHARGE	100% of R&C*	
OUTPATIENT NON-SURGICAL DOCTOR'S VISITS, including Physical Therapy, limited to one visit per day; Physical Therapy is limited to 9 visits		
- First visit	$120	$60
- Each visit thereafter	$60	$30
DURABLE MEDICAL EQUIPMENT, including orthopedic appliances	$100	$50
AMBULANCE CHARGES	100% of R&C*	$250
OUTPATIENT X-RAY SERVICES	$500	$250
OUTPATIENT IMAGING PROCEDURES, including interpretation for MRI/CAT Scan	$900	$500
PRESCRIPTION DRUGS	100% of R&C*	$50
DENTAL TREATMENT, for Injury to Sound Natural Teeth, per tooth	$300	$150
EYEGLASS REPLACEMENT EXPENSE, for broken eyeglasses, lenses or contact lenses resulting from an Injury requiring medical treatment	$150	$100
RE-AGGRAVATION OR RE-INJURY OF A PRE-EXISTING CONDITION.	$500	$500
For the benefits shown below only one of the amounts, the largest, will be paid for loss resulting from any one Accident		
ACCIDENTAL DEATH, caused by an Injury and occurring within 365 days of covered Accident	$5,000	$5,000
ACCIDENTAL DISMEMBERMENT, caused by an Injury and occurring within 365 days of covered Accident		
- Loss of one hand, one foot or one eye	$5,000	$5,000
- Loss of hands, feet or eyes	$10,000	$10,000

***The Policy provides benefits for Reasonable and Customary (R&C) charges determined by geographic area for Medically Necessary services.**

EXTENDED DENTAL BENEFIT OPTION: For an additional premium the Dental Treatment Benefit will be increased to pay all Reasonable and Customary charges for: examination, diagnoses and x-ray; restorative treatment; endodontics; and oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture or denture, or for replacement in kind of previous dental repairs. If during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, GTL will pay up to a maximum of $100 in lieu of all other dental benefits.

EXCESS PROVISION: All Covered Charges over $500 will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance or Plan covers the Insured person. GTL will pay the first $500 in Covered Charges regardless of other insurance.

EXCLUSIONS: The Policy does not provide benefits for: 1. Treatment, services or supplies which: are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are determined to be Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy; 2. Intentionally self-inflicted Injury; 3. Injury received while violating or attempting to violate any duly enacted law; 4. Injury by acts of war, whether declared or not; 5. Injury covered by Workers' Compensation or the Occupational Disease Law; 6. Heat exhaustion or heat stroke; 7. Hernia or slipped femoral capital epiphysis; 8. Injury sustained fighting or brawling, except as an innocent victim; 9. Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four- wheeled recreational motor/engine driven vehicle or snowmobile or all-terrain vehicle (ATV); 10. Injury sustained while by participating in or practicing for Interscholastic tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased; 11. Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance; 12. Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; 13. Charges for treatments, services or supplies which exceed reasonable and customary charges; 14. Losses directly or indirectly arising out of any chemical or biological release and/or contamination which results from Terrorist Activity; 15. Any loss as the result of Terrorist Activity and/or non-detonating weapons of mass destruction; or 16. Any loss directly or indirectly arising out of any nuclear explosion, detonation, release and/or contamination whether in time of peace or war, and regardless of any other causes or events contributing concurrently or in any other sequence thereto.

Administered by: **PACIFIC EDUCATORS, INC.**, 2808 E. Katella Ave., Suite 101, Orange, CA 92867-5299
(714) 639-0962 or (800) 722-3365 - Pacific Educators' California License No. 0429928
Underwritten and Claims Paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**, Glenview IL - (800) 622-1993

2026-27 School Year Enrollment Form

ONE TIME ANNUAL PAYMENT		
OPTIONS	**High Option**	**Low Option**
24-HOUR-A-DAY PLAN **$50,000 Maximum per Injury**		
Grades Pre-K thru 8	❑ $161	❑ $75
Grades 9 thru 12	❑ $192	❑ $92
SCHOOL-TIME PLAN **Maximum per Injury:** **$50,000** for High Option **$25,000** for Low Option		
Grades Pre-K thru 8	❑ $25	❑ $11
Grades 9 thru 12	❑ $54	❑ $24
OPTIONAL FOOTBALL COVERAGE (2026 Season Only) Payable in addition to School-Time & 24-Hour **$25,000 Maximum per Injury**		
Grade 9	❑ $80	❑ $36
Grades 10 thru 12	❑ $177	❑ $84
EXTENDED DENTAL OPTION	❑ $6	

TOTAL $ _____
(Please do not send cash)
MAKE CHECK PAYABLE TO:
PACIFIC EDUCATORS, INC.

NO REFUNDS ARE AVAILABLE

PLEASE PRINT CLEARLY

GTL Guarantee Trust Life

Student's Name _____
First Name Middle Initial Last Name

Date of Birth _____ **Male** ❑ **Female** ❑
Month Day Year

School District _____ **School** _____

Grade _____ **Student's Address** _____

City _____ **State** _____ **Zip** _____

Telephone # _____ **Date of Enrollment** _____

Parent or Guardian's Email Address _____

Name of Parent or Guardian (please print) _____

Signature of Parent or Guardian _____

GA-15-KEF

TO PAY BY CREDIT/DEBIT CARD (fee applies) PLEASE GO TO:
WWW.PEINSURANCE.COM OR CALL (800) 722-3365

PLEASE REMEMBER TO:

COMPLETE THE ENROLLMENT FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.

MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE ENROLLMENT FORM WITH YOUR CHECK OR MONEY ORDER TO:

Pacific Educators, Inc.
2808 E. Katella Ave., Suite 101
Orange, CA 92867-5299

PLEASE NOTE: YOUR CANCELED CHECK IS YOUR RECEIPT. IF CANCELED CHECK IS NOT RECEIVED WITHIN 60 DAYS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR.

For faster service you can pay by credit or debit card (fee applies) please visit us online at:
Pacific Educators
www.peinsurance.com
click Products then Students
or call (800) 722-3365

Pacific Educators
FREE Prescription Drug Card

Member: California Student
ID Number: 26291W22ES
Program: UNARxCard
RxBIN: 610709
RxGrp: PFCEDU

Note: Everyone is eligible for this program. There are no age or income restrictions. Each family member must have his/her own card. If you can't print a card have your pharmacy call the Pharmacy Help Line and we will help them process your prescription.

THIS PROGRAM IS NOT INSURANCE
THIS PROGRAM IS A POINT OF SALE DISCOUNT PLAN

INSTRUCTIONS **This card is pre-activated and can be used immediately. Simply print this card and take to any participating pharmacy to receive a discount. You can search pharmacy, pricing information, and FAQ's on the website. We are restricted from disclosing drug pricing over the phone.**
Customer Service (TOLL FREE) 800-726-4232

ATTENTION PHARMACIST **If you need help processing a prescription call our Pharmacy Help Line at Pharmacy Help Line (TOLL FREE) 877-321-6755.**

PROGRAM POWERED BY:

United Networks OF AMERICA UNARx Card

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IMPORTANT: PRINT CARD. YOU WILL NEED TO BRING THIS CARD TO THE PHARMACY WITH YOUR PRESCRIPTION.

We are proud to announce that Pacific Educators is now making available a **FREE Prescription Drug Card Program** to help anyone lower their prescription drug costs.

This card can be used with a primary plan and/or on prescriptions not covered by your insurance plan. It also can be used even if you don't have any insurance. The Rx Card Program has no restrictions or participation requirements and is open to anyone.

This Free Prescription Drug Card is pre-activated and can be used immediately.

