2014–2015 Student Accident Insurance Plans

Why you need Student Insurance . . .

- Your school does not provide medical insurance to cover injuries to students. Instead, your school suggests this Plan to provide affordable coverage options.
- If you don't have other insurance, this Student Accident Plan is essential.
- Even if you do have other insurance, you will probably have to pay deductibles or co-payments. This Student Accident Plan will help to fill those expensive "gaps."
- Don't wait until you're faced with costly medical bills to think about insurance.
- Read this information and make your selections today!

Choose from these school approved plans . . .

- **Around-the-Clock Plan**
- **Schooltime-Only Plan**

– plus –

- **Extended Dental Plan**
- **Football Plan**

UNDERWRITTEN BY:

COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
Commercial Travelers Building
Utica, NY 13502

SERVICED BY:

LEFEBVRE INSURANCE AGENCY
850 Franklin Street
Wrentham, MA 02093
800-451-9668

As Policy Form Series No.: In ME: CTP-7-NER (08) et al; and in NH: Form CTP-7 et al

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1 Choose from these School-Approved Plans:

Around-the-Clock Plan

The student is insured for full 24-hour a day protection, for school-connected accidents, and at home or away—at play—at camp—on vacation—scouting—amateur sports—youth group activities—or just playing in the neighborhood. Coverage for interscholastic tackle football played in or with grades 10–12 must be purchased separately.

Schooltime-Only Plan

The student is insured while attending school when school is in session; participating in or attending activities sponsored solely by the school and directly and continuously supervised by a school official or employee, including all sports except interscholastic tackle football played in or with grades 10–12 (unless you purchase football coverage) as well as travel by school-furnished transportation during the school term; traveling to or from the Insured's residence and the school for regular school sessions; and attending religious classes, including travel.

Football Coverage

Covers injuries caused by accidents occurring while participating in interscholastic tackle football played in or with grades 10–12, or while traveling as a team member in a school-provided vehicle to or from football games or practice, when such travel is sponsored by the school and supervised by school employees. Maximum Medical Benefit is $25,000 with an optional $100 deductible. 9th grade tackle football is covered under the Schooltime-Only or Around-the-Clock Plans.

Extended Dental Plan

Increases the Dental Treatment Benefit for accidental injury to sound natural teeth under the Plans to a maximum of $25,000 as the result of any one accident. This extended coverage is effective 24 hours a day even when selected with Schooltime-Only Coverage and ends on the opening day of school for the following Fall term. Premium for the Extended Dental Benefit is $16.00 under all plans. Extended Dental Coverage may *not* be purchased by itself.

2 Additional facts about the Plans:

Effective and Expiration Dates: Applicants are covered as of the day following the envelope postmark date, but not prior to the opening day of school. The expiration date of coverage under the **Schooltime-Only Plan** is the close of the regular nine month school term, except while the Insured is attending academic classroom sessions, exclusively sponsored and solely supervised by the school during the summer; in such case coverage will terminate at the end of the summer classroom sessions. **Around-the-Clock** coverage ends on the opening day of school for the following Fall term. **Football Coverage** starts the first day of authorized practice, provided premium is paid prior to that date, and expires 7/1/15.

Student Accident Insurance covers accidental bodily injury sustained during the term of insurance and which causes loss directly and independently of all other causes. Insurance is good anywhere. For example, if the student buys the Plan at school and the family moves, coverage will continue until the close of the school term at any new public or parochial day school. There is no limit to the number of accidents a student can have paid under the Policy.

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3 Your choice of benefits

The Policy will pay up to $250,000 for covered expenses incurred as the result of Accidental Bodily Injury sustained in any one Accident which occurs on or after the effective date of coverage. The first such expense must be incurred within 90 days of the accident (60 days for dental treatment) and the covered treatment, care or service rendered within 52 weeks of the accident. Benefits for covered expenses shall not exceed the specified amounts. The first $100 of covered expenses incurred as a result of each covered accident claim will be paid, regardless of any other insurance. If expenses exceed $100, the claim will then be paid on **AN EXCESS BASIS,** if other insurance or medical service plans are involved (see **LIMITATIONS**). All benefits are per accident, unless otherwise specified.

	Standard Plan	Preferred Plan
Aggregate Benefit Limits		
MAXIMUM MEDICAL BENEFIT (Schooltime or 24-Hour Plans)	$100,000	$250,000
OPTIONAL FOOTBALL BENEFIT	$25,000	$25,000
OPTIONAL DENTAL INJURY BENEFIT	$25,000	$25,000
MOTOR VEHICLE INJURIES	$5,000	$5,000
ACCIDENTAL DEATH BENEFIT	$5,000	$5,000
DISMEMBERMENT BENEFIT (Single/Double)	$10,000/$20,000	$10,000/$20,000
Hospital/Facility Services—Inpatient		
HOSPITAL ROOM AND BOARD—Semi-Private Room	$300/day	$500/day
HOSPITAL INTENSIVE CARE—When prescribed by the attending physician	$500/day, 3 days max.	$1,000/day, 5 days max.
HOSPITAL MISC. EXPENSE—Not under another benefit	$300/day	$500/day
Hospital/Facility Services—Outpatient		
HOSPITAL OUTPATIENT/EMERGENCY ROOM TREATMENT—Includes facility fees, Physician fees, and supplies	$375/day	$750/day
OUTPATIENT SURGICAL FACILITY OTHER THAN AN EMERGENCY ROOM	$250/day	$500/day
Physician's Services		
SURGEON EXPENSES—Expenses for the Physician Conducting an Inpatient or Outpatient surgical operation	70% UC&R not to exceed $1,500	80% UC&R not to exceed $2,500
ASSISTANT SURGEON EXPENSE—Only if Surgeon Expense is paid	25% of Surgeon Expense	25% of Surgeon Expense
ANESTHESIOLOGIST EXPENSE—Only if Surgeon Expense is paid	25% of Surgeon Expense	25% of Surgeon Expense
PHYSICIAN'S PHYSIOTHERAPY OUTPATIENT TREATMENT—Outpatient physiotherapy or spinal manipulation, if treatment is prescribed for a covered Loss	$35 for the 1st visit; $25 for each subsequent visit, 5 visits max.	$50 for the 1st visit; $25 for each subsequent visit, 5 visits max.
PHYSICIAN'S PHYSIOTHERAPY INPATIENT TREATMENT—Inpatient therapy or spinal manipulation, if treatment is prescribed for a covered Loss	10 days	20 days—$500/day
PHYSICIAN'S OUTPATIENT TREATMENT—Outpatient visits that require a Physician other than a Surgeon, except for Physiotherapy or spinal manipulation	$40 for the 1st visit; $25 for each subsequent visit, 5 visits max.	$50 for the 1st visit; $25 for each subsequent visit, 5 visits max.
CONSULTING PHYSICIAN—Second opinion	$50	$100
Other Services		
REGISTERED NURSES' SERVICES—Except for nursing services provided in connection with Anesthesiology	UC&R	UC&R
LABORATORY TESTS—OUTPATIENT—When prescribed by the attending physician	$100	$250
PRESCRIPTION MEDICATIONS—OUTPATIENT—Dispensed by licensed pharmacist when prescribed by the attending physician; mechanical devices excluded	$100	$100
X-RAYS—OUTPATIENT—When prescribed by the attending physician; includes interpretation	70% of UC&R not to exceed $200	80% of UC&R not to exceed $250
DIAGNOSIS IMAGING—OUTPATIENT—When prescribed by the attending physician; Includes MRI & CAT Scans and interpretation	70% of UC&R not to exceed $200	80% of UC&R not to exceed $250
AMBULANCE EXPENSE—One trip per Injury from scene of Accident	UC&R for ground; $500 for air	UC&R for ground; $1,000 for air
ORTHOPEDIC BRACES AND APPLIANCES—When prescribed by the attending physician	$100	$200
DENTAL TREATMENT—For Injury to sound and natural teeth	$200 per tooth; max. of $5,000	$300 per tooth; max. of $10,000
REPLACEMENT OF EYEGLASSES, HEARING AIDS & CONTACT LENSES—Only when medical treatment for the Injury is covered	$100	$200

"UC&R" means usual and customary charges in the area where the treatment or service is provided.

AD&D Benefits

For loss of:

Life	$ 5,000.00
Double dismemberment/quadriplegia	20,000.00
Single dismemberment/paraplegia/hemiplegia	10,000.00
Loss of thumb and index finger of same hand	5,000.00

If within 100 days from the date of a covered accident, injuries cause dismemberment or death, the largest applicable indemnity will be paid, IN ADDITION to benefits for medical expense.

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Exclusions

This plan does not cover, nor is any premium charged for: (a) Injuries resulting from the practice or play of interscholastic tackle football in or with grades 10–12, unless the proper additional premium per player has been paid. (b) Intentionally self-inflicted injuries. (c) Infection, except pyogenic infection or bacterial infection due to accidental ingestion of contaminated material. (d) Treatment administered by any person employed or retained by the school. (e) Hernia in any form. (f) Illness or disease in any form. (g) Injuries sustained while operating, riding in or on, or alighting from a two- or three-wheeled engine-driven or motorized vehicle, or any vehicle not designed primarily for use on public streets and highways. (h) Injuries sustained as a driver or passenger in or on any other motorized or engine-driven vehicle, except travel in a 4-wheeled passenger vehicle, bus or train to or from school or school sponsored and supervised activities, unless Around-the-Clock coverage is purchased or as otherwise provided. (i) Air travel or the use of any device or equipment for aerial navigation, except as a fare-paying passenger on a regularly-scheduled commercial airline. (j) Injury resulting from intoxication or the use of drugs or narcotics, unless administered on the advice of a physician. (k) Injuries resulting from war or any act of war, active participation in any riot or civil commotion. (l) Nuclear reaction or radiation. (m) Reinjury or complications of a condition due to accidental bodily injury occurring prior to the effective date of coverage. (n) Injuries sustained as the result of the insured's participating in skiing in any form, except when the Around-the-Clock Coverage is purchased, or as a member of an Intramural or Interscholastic skiing team or club.

Limitations

(1) No payment shall be made for expenses in excess of $100.00 per accident for which hospital, medical, surgical or dental benefits are payable or service is available under any other insurance or medical service plan, including HMO's, PPO's, Workers' Compensation, Employer's Liability Act or Law, Automobile No-Fault and similar plans. (2) No benefits are payable for any expense resulting from participation in interscholastic athletics for which benefits would be payable, in the absence of insurance hereunder, under any High School Association Catastrophe Sports Accident Policy. (3) Under surgery, the maximum payment for multiple procedures performed within the same operative field shall be limited to 150% of the amount payable for the primary procedure. (4) In the event the Insured Person sustains an injury for which benefits are payable under more than one Student Accident Insurance Policy or like coverage issued by the Company, coverage shall be deemed to be in effect only under one such Plan, the one affording the greater (or greatest) amount of benefits for the injury.

Note: *Certain of these exclusions or limitations may be modified to meet individual state requirements.*

How to file a claim

In case of an accident, simplified claim forms are available at the school. Accidents must be reported and bills submitted within 90 days. If the student is insured under the "Around-the-Clock Plan" and school is not in session, or has transferred to another school, a claim form can be obtained from the Administration Office on the cover, or from www.commercialtravelers.com.

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary state approvals. Any provision of the Policy, as described herein, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits. This plan is not available in all states.

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4 How to apply

- Choose the plan best suited to your needs.
- Complete and sign the attached enrollment form.
- Send check or money order payable to **Commercial Travelers** for the required yearly premium.
- Mail to: **Lefebvre Insurance Agency, 850 Franklin St., Wrentham, MA 02093.**

IMPORTANT Keep this information as a Summary of Benefits. The Policy is on file at your school. It is subject to Insurance Department approval and will conform to the laws of the state where your school is located. Individual policies will not be sent to you.

LATE ENROLLMENT Coverage may be purchased at any time during the school year, but there is no premium reduction for late enrollment.

CANCELLATION Coverage is non-cancellable and premiums will not be pro-rated or refunded.

RETURN OF CHECK BY BANK Coverage will be immediately invalidated if check is returned by bank for any reason.

CUT AND MAIL

Enrollment Form

Yearly Student Rates—2014–2015—Check Your Selections

COVERAGE OPTIONS	BENEFIT OPTIONS	
	❐ **Preferred Plan**	❐ **Standard Plan**
Around-the-Clock Plan	❐ **$232.00**	❐ **$193.00**
Schooltime Plan	❐ **$ 56.00**	❐ **$ 42.00**
Extended Dental*	❐ **$ 16.00**	❐ **$ 16.00**
Football—No Deductible	❐ **$295.00**	❐ **$191.00**
Football—$100 Deductible	❐ **$257.00**	❐ **$164.00**
Total Payment Enclosed	**$**	**$**

***Note: Extended Dental Coverage is available only in combination with 24-Hour or School-time Coverage.**

Make Check or Money Order Payable to **"COMMERCIAL TRAVELERS"** ***DO NOT SEND CASH***

STUDENT'S LAST NAME *Please print child's name clearly—1 letter to a box* STUDENT'S FIRST NAME MIDDLE INITIAL

GRADE BIRTHDATE (Mo/Day/Yr) PARENT'S PHONE NO.

PARENT'S NAME

HOME ADDRESS
No. & Street Apt. # City State Zip

NAME OF SCHOOL

SCHOOL DISTRICT OR ADDRESS (CITY)
City State

ME: 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.

NH: 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.

SIGNATURE
(Parent or Guardian) Date Signed

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IMPORTANT! THIS IS YOUR INSURANCE CARD. IF COVERAGE IS PURCHASED CLIP, FOLD AND CARRY AS YOUR VERIFICATION OF COVERAGE.

This card verifies student accident coverage during the 2014–2015 school year for:

Name of student

Name of school

Plan Number MWX-NER-14

Fully Insured & Underwritten by Commercial Travelers Mutual Insurance Company

Send completed claim form and itemized bills to: COMMERCIAL TRAVELERS, Attn: School Claims • 70 Genesee St. • Utica, NY 13502
commercialtravelers.com • 1-800-756-3702

Possession of this card does not guarantee eligibility. The student must be enrolled in the plan. Eligibility is subject to Verification by Plan Administrator.

FOLD

List Medical Conditions:

Family Physician:

Phone ( )

Coverage Purchased:

❐ Accident Only Coverage
- ❐ Around-the-Clock
- ❐ Schooltime
- ❐ Dental
- ❐ Football—$100 Deductible
- ❐ Football—No Deductible

Plan Administered by:

COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Please check the correct Underwriting Company:

❑ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
❑ NIAGARA LIFE AND HEALTH

Instructions

1. PART A — must be completed by the school.
2. PART B — must be completed by Parent or Guardian
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the claims administrator separately. Please show name of school on all later bills.
4. Mail this report and bills within 90 days after the first treatment to:

Special Risks Claims
Commercial Travelers Mutual Insurance Company
70 Genesee Street • Utica, NY 13502

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

If you have submitted an accident report to another insurance company, please attach a copy.

Name of School Phone No. ( )		School District/Policyholder
Address Street/Box# City State Zip		Policy No.
Name of Student	❒ Male ❒ Female	Grade

Date of Accident / /	How Accident Occurred
Time of Accident ❒ AM ❒ PM	❒ Enroute to/from school ❒ During school session ❒ Practice or play of interscholastic sports Name of Sport ____________ ❑ JV ❑ Varsity ❒ Other ____________

How did accident happen?

Details of Injury — including part of body injured:

Name of Teacher or Coach Supervising the Activity

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of School Official/Title	Date Signed

—Reverse side must be completed by parent or guardian—

Accident Claim Form

Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Social Security No.	Date of Birth / /	Date of Accident / /

Name of Person Making this Report	Relationship to Student
Address Street/Box# City State Zip	Telephone Home ( ) ______ Work ( ) ______

Name of Student's **Male Parent** or Guardian Address if different from student	Occupation	Social Security No.

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Name of Student's **Female Parent** or Guardian Address if different from student	Occupation	Social Security No.

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Does either parent or guardian have Accident/Health Insurance which covers this student? ❒ Yes ❒ No
If yes, which person(s)

Name of Insurance Company(ies)	Name of Policyholder(s)

For Around-the-Clock Coverage only:

Date of injury (or) onset of sickness ______ When was physician first consulted? ______

Nature of injury (or) illness ______

If injury, how and where did accident occur? ______

Have you suffered same or similar condition in the past? ❒ Yes ❒ No If "Yes,' and if you were treated for, it, please give name and address of the physician who treated you ______

Dates treated ______

Give name, address and telephone number of usual family physician ______

______ Phone ______

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student ______

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of Parent or Guardian	Date Signed

AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

AL, AR, DC, LA, MA, and RI: 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.

AZ: 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.

CA: For your protection California law requires the following to appear on this form: 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.

CO: 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."

FL: 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.

GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

KY: 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.

ME: 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.

MD: 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.

NH: 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.

NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

OH: 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.

PA: 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.

OK: 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.

TN: 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.

VA, WA: 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 or a denial of insurance benefits.

WV: 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.