Student accident insurance 2019-2020

Choose your coverage plan

One-time premium for the 2019-2020 school year.
Coverage availability varies by state.

School time coverage (accident only)

Low plan: $15.00 Middle plan: $36.00 High plan: $66.00

The school time plan provides coverage while an insured student is in or on school premises during the days and months when school is in session; traveling directly to or from their residence and school in a vehicle supplied by the school; and participating in or attending activities sponsored solely by the school that are continuously supervised by a school official or employee. This also includes supplied and supervised travel directly to and from such sponsored activities; and school sponsored and supervised sports, **excluding ninth-, tenth-, eleventh-, and twelfth-grade interscholastic football**.

Around the clock coverage (accident only)

Low plan: $68.00 Middle plan: $144.00 High plan: $266.00

Around the clock coverage applies 24 hours a day, whether school is in session or not. The insurance is provided from the effective date of the insured student's coverage to the termination date of the policy. This coverage includes school sponsored and supervised sports, **excluding ninth-, tenth-, eleventh-, and twelfth-grade interscholastic football**.

Summer day camp/Off season conditioning

Low plan only: $11.00

Provides coverage during school sponsored and supervised summer day camps that are conducted on school premises. Off season conditioning provides coverage when under the direct supervision of the coach or a trainer for conditioning and weight training for interscholastic sports which takes place at a designated facility on the premises or in close proximity to the school. It does not provide coverage for play or practice involving bodily contact of any sport. This coverage ends the first day of official practice or the first day of school, whichever comes first.

Interscholastic football coverage

- Provides coverage for ninth-, tenth-, eleventh-, and twelfth-grade interscholastic football only.
- **School time and around the clock coverage is not included with this plan option.**

Annual
Low plan: $109.00 Middle plan: $294.00 High plan: $435.00

Spring only
Low plan: $38.00 Middle plan: $118.00 High plan: $174.00

How to enroll

- **Enroll online at http://markel.sevencorners.com or call 877-444-5014 for enrollment by phone.**
  Seven Corners, Inc. is Markel's administrator for this program.
- **Payment must be made by credit or debit card.**

Review your benefits

Maximum benefits paid as specified

The policy provides benefits for loss due to a covered Injury up to the maximum benefit as listed below for each Injury. Benefits will be paid for covered medical expenses incurred within 52 weeks from the date of Accident up to the maximum benefit per service as scheduled.

Retain this description of coverage for your personal records

Individual policies will not be issued or sent to you. This brochure is for illustrative purposes only. It is not a contract of insurance. It is intended to provide a general overview of the insurance program.

This is only a partial description of the insurance plan. The benefits which are payable are determined in accordance with the terms, conditions, and exclusions of the policy which is on file with the policyholder (school or district office).

Description of benefits

Benefit	Low plan	Middle plan	High plan
Plan maximum	$25,000	$50,000	$75,000
Hospital room and board	$125 per day	$200 per day	$350 per day
Hospital miscellaneous	80% U&C to $1,000 maximum	80% U&C to $1,200 maximum	80% U&C to $2,400 maximum
Room and board - intensive care	$250 per day/$1,000 maximum	$250 per day/$1,000 maximum	$500 per day/$2,000 maximum
Licensed nurse	Usual and customary	Usual and customary	Usual and customary
Outpatient emergency room	$200	$200	$350
Outpatient x-ray	$200	$250	$400
Outpatient CT Scan/MRI	$300	$300	$500
Ambulance	$150	$150	$300
Surgery	50% U&C up to $1,000	50% U&C up to $1,250	80% U&C up to $1,750
Anesthetist/assistant surgeon	$250	$315	$440
Outpatient consultant	$40	$50	$95
Outpatient physician	$40 for the first visit/$25 thereafter	$40 for the first visit /$25 thereafter	$60 for the first visit/$35 therefter
Outpatient day surgery	$350	$350	$600
Outpatient physical therapy	$25 per visit, 10 visit max	$25 per visit, 10 visit max	$40 per visit, 10 visit max
Outpatient durable medical equipment & supplies	$75	$75	$150
Dental injury	$150 per tooth	$150 per tooth	$300 per tooth
Outpatient prescription drugs	$25	$25	$50
Replacement of eyeglasses, hearing aids	$150	$150	$300
Motor vehicle accident limit	$2,500	$2,500	$2,500
Accidental death	$5,000	$5,000	$5,000
Accidental dismemberment	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000

Definitions

- Accident means a sudden, unexpected and unintended event, which is identifiable and caused solely by an external physical force resulting in Injury to an insured student. Accident does not include a loss contributed to by disease or sickness.
- Injury means bodily harm caused solely by an Accident which occurs while this policy is in force and is the sole cause of the loss.
- Usual and customary expense (U&C) means an expense which (a) is charged for treatment, supplies or medical services medically necessary to treat the insured student's condition; and (b) does not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where the expense is incurred.

Additional facts about the policy

1. Student transfer: The policy continues in force anywhere in the world if the insured person should relocate prior to the expiration of coverage. Coverage will not exceed the limits shown in this brochure and must be in accordance with accepted standards of medical practice.
2. Cancellation: Coverage under the policy is non-cancelable, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event an insured enters the military service.
3. Initial enrollment: Coverage is effective on the day following online or phone enrollment, but in no event prior to the opening day of school or the first official day of interscholastic athletics or activities.
4. Late enrollment: There is no premium reduction for any individual who enrolls late in the year.
5. Enrollment: Deadline is 6/14/20.

Accidental death & dismemberment limitations

- The loss must result from an Accident, and must take place while the insured person is insured under the policy. We will not pay for a loss caused in any way by:
- Bodily or mental infirmity or illness;
- Medical or surgical treatment; except for surgery which results from an Accident;
- Taking part in a riot or felony.

How to file a claim

1. Obtain a claim form from your school office or Seven Corners, Inc. (877-444-5014), and answer all questions in detail (including signatures) on the front of the form.
2. Attach all bills to the completed form and mail to Seven Corners, Inc. at the address provided on the claim form.
3. Any bills not filed with the claim form should be sent to the company, identified with the student's name, school district, and date of accident. Bills that cannot be attached to the initial form must be submitted within 90 days of the date of service.

Policy exclusions and limitations

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

- Sickness;
- Expense for treatment on or to the teeth, except for treatment resulting from Injury to sound, natural teeth;
- Services normally provided without charge by the policyholder;
- Eyeglasses, contact lenses, hearing aids, and examination for the prescription or fitting there of except as specifically provided herein;
- Suicide, attempted suicide, or intentionally self-inflicted Injury;
- Injury due to participation in a riot or felony;
- Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery made medically necessary due to a covered Accident which results in trauma, infection, or other diseases of the involved part;
- Treatment of a deviated nasal septum, including submucous resection and/or other surgical corrections, unless the treatment is due to or arises from a covered Injury;
- Air travel, except as a fare-paying passenger on a regularly scheduled flight operated by a commercial airline;
- Injury resulting from any declared or undeclared war;
- Injury while in the armed forces of any country. When an insured person enters such armed forces, we will refund the unearned pro-rata premium to the insured person;
- Injury covered by any workers' compensation or occupational disease law;
- Treatment provided in a governmental hospital unless the insured person is legally obligated to pay such charges;
- Infections except pyrogenic or bacterial infections caused by a covered Injury;
- Hernia, unless it results from a covered Injury;
- Injury occurring while the insured person is legally intoxicated or under the influence of any narcotic unless administered on the advice of a physician;
- Injury while parachuting or hang gliding; traveling in or on any two-, three-, or four-wheeled all-terrain motor vehicle; jet skiing, skydiving, glider flying, parasailing, sail planing, bungee jumping; operating or riding on any snowmobile; skiing, snowboarding; or participating in a rodeo;
- Injury resulting from fighting;
- Play, practice, or travel in connection with interscholastic football in which any ninth-, tenth-, eleventh- or twelfth-grade students participate, unless the applicable additional premium is paid;
- Blisters, insect bites, frostbite, vegetation poisoning and food poisoning;
- Motor vehicle accidents covered by medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

MARKEL®

Return Completed form to:
Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032
P: 877-444-5009 / **F**: 317-575-2256
Markel.claims@sevencorners.com

K12 Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.

In order to pay claims we must have your Social Security Number

Part 1 – POLICYHOLDER'S REPORT

Name of School	Name of Policyholder				Policy Number
Claimant's Name	Gender ☐ Male ☐ Female				Date of Birth
Social Security Number (Required)	E-mail Address				
Claimant's Address	City		State	Zip	Phone Number
Parent's Name (if applicable)	Parent's Address (if applicable)	City	State	Zip	Phone Number

1. Date and time of accident: _____ Place where the accident occurred: _____

2. Was the injured person: ☐ Student ☐ Interscholastic Sports Participant Grade Level: _____

FOR DENTAL CLAIMS ONLY

3. Indicate which teeth were involved in the accident: _____

4. Describe condition of injured teeth prior to accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

5. Nature of injury: _____
(indicate part of body injured – e.g. broken arm, sprained ankle, etc.)

6. Describe how the accident occurred – give all possible details – must be a bodily injury due to accident:

_____

7. Did the accident occur:

- **A.** During a policyholder sponsored & supervised activity? ☐ Yes ☐ No
- **B.** During programmed hours? ☐ Yes ☐ No
- **C.** On activity premises? ☐ Yes ☐ No
- **D.** While traveling directly to or from a sponsored event? ☐ Yes ☐ No

8. Name of the event or activity: _____ Name and Title of Supervisor: _____

9. Representative Signature _____ Title _____ Date _____

Part 2 – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health coverage through an employer or other source? ☐ Yes ☐ No

If Yes, Name of insurance company _____ Policy # _____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐ Yes ☐ No

If Yes, Name of insurance company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse Markel Insurance Company to the extent of any amount collectible.

Claimant, Parent or Authorized Representative's Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative's Signature: _____ **Date:** _____

If Authorized Representative, Relationship to Patient or Legal Designation: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative's Signature: _____ **Date:** _____

If Authorized Representative, Relationship to Patient or Legal Designation: _____

PLEASE NOTE

In furnishing this or other claim forms for the convenience of the claimant, MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

FRAUD STATEMENTS

GENERAL: 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.

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: 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 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.

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 RESIDENTS: 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 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim 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: Any 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.

LOUISIANA: 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.

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 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.

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 fines and criminal penalties.

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.

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.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND: 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.

TENNESSEE: 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.

VIRGINIA: 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.

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.

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.