Hilliard City School District

David Stewart, Superintendent • Melissa Swearingen, Treasurer/CFO

Dear Parents,

Our school district has made arrangements with Student Protective Agency to provide student accident and health insurance for those wishing to purchase coverage this year. Please note the coverage shown on the application. Covered losses less than $250 are paid without regard to other insurance. Please note the option to purchase 24 hour accident and sickness coverage is available to be purchased within 75 days of the school year or moving into the district with loss of other coverage.

Senior High football coverage requires an additional premium. All other school supervised sports are covered under the plan. On claims over $250 this is an excess coverage policy for which benefits are payable only for that part of the loss not covered by other collectible insurance. If a person has no other insurance, the Company will pay the covered medical expenses incurred within one year, up to the specified limits of the policy.

Please not that the student applications will be available on our website. Complete the application and check the boxes for coverage desired. Sign where life insurance is shown, if desired. Tear off and keep the rest of the applications, as it shows not only the coverage but the exclusions and limitations of the policy.

Mail the applications directly to Student Protective Agency, 300 Coshocton Avenue, Mount Vernon, OH 43050 along with a money order or check payable to Student Protective or go to www.Studentprotective.com. The school will be notified as to who takes out coverage. You can call Student Protective at 1-800-278-2544 for more information.

In case of an accident the student or parent should immediately go to the building principal who will sign and provide the claim form if only school time coverage is taken out. 24 hour coverage needs no signature. The policy number shall be provided by the school for the claim or you can call 1-800-278-2544. You may give that policy number to the doctor or hospital but the bills should be sent to the parent or guardian who attach them to the claim form. Once completed, mail to the claims office at Guarantee Trust Life Insurance, PO Box 1148, Glenview, IL 60025. If you have any further questions regarding a claim, please call 1-800-622-1993. It is the responsibility of the parent or guardian to file the claim.

2024-25 OHIO

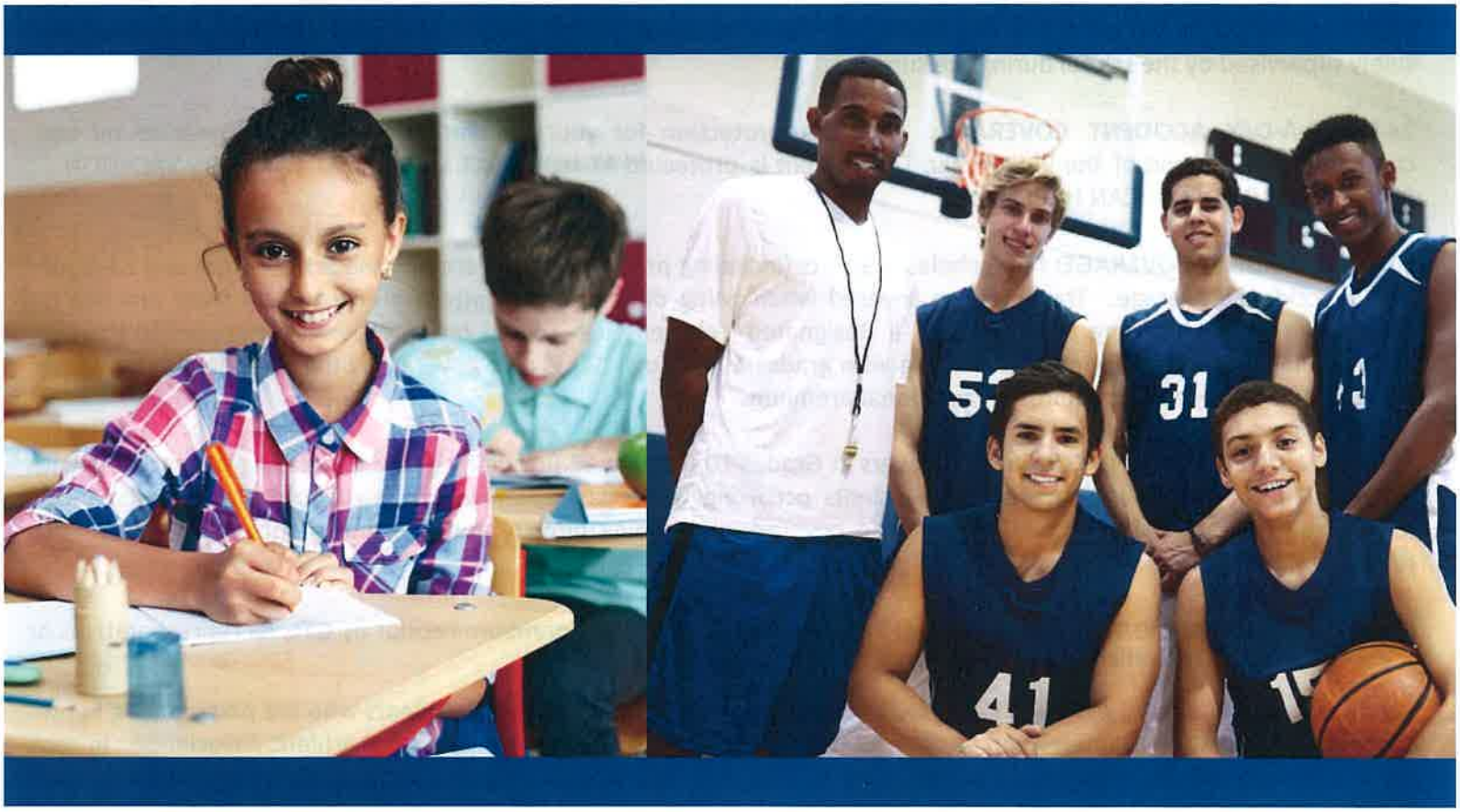
STUDENT ACCIDENT INSURANCE PROGRAM

Multi-Benefit Protection

Plan Administered by:

Student Protective Agency

300 Coshocton Ave.
Mount Vernon, OH 43050
1-800-278-2544



ACCIDENT INSURANCE PROTECTION HELPING PROVIDE:

For the Student - Sound coverage with a selection of plan options

For the Parent - Additional financial security to help in times of increasing medical costs

For You - The fulfillment of an administrative service and responsibility

Underwritten & Claims Administered by:

GTL | GUARANTEE TRUST LIFE

Guarantee Trust Life Insurance Company (GTL)
1275 Milwaukee Ave., Glenview, IL 60025
1-800-622-1993
www.gtlic.com

GB-OH-24

ACCIDENT INSURANCE PLANS

for all students and athletes

SCHOOL-TIME STUDENT ACCIDENT COVERAGE: Helps protect your students the entire school year, during regular school sessions, as well as participating in other school-sponsored activities requiring the attendance of the student. Also provides protection for your students while traveling directly to or from the student's Residence and school to attend or participate in school activities. The expiration date of coverage shall be 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.

24-HOUR-A-DAY ACCIDENT COVERAGE: Provides protection for your students 24-hours-a-day, year-round and continues until the end of the Policy Year. The student is protected AT HOME, AT SCHOOL, AT CAMP, ON VACATION. . . ANYWHERE ACCIDENTS CAN HAPPEN.

SPORTS ACCIDENT COVERAGE: Interscholastic sports (including practice) are covered by the School-Time and 24-Hour-A-Day Accident Coverage. Travel is also covered when going directly and uninterruptedly to and from practice or competition when traveling as a group in a Designated Vehicle. High school tackle football for grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) is only covered by the optional Football Only Accident Coverage, which requires an additional premium.

FOOTBALL ONLY ACCIDENT COVERAGE: Players in Grades 10 through 12 (including grade 9 if playing or practicing with grades 10 through 12) are covered for accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is also covered when going directly and uninterruptedly to and from such practice or competition when traveling as a group in a Designated Vehicle.

EFFECTIVE COVERAGE DATES: Coverage will be effective on the date of premium receipt by GTL, its representatives or school officials, or the official first day of school, whichever is later.

For interscholastic sports, coverage can pre-date the official first day of school for students who are participating in pre-school practice sessions, competition or covered travel sanctioned by the Ohio High School Athletic Association. In such cases coverage will be effective as of the date of premium receipt but only while participating in actual practice sessions, competitions or covered travel. Other aspects of coverage will not commence until the official first day of school.

Football Only Accident 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 no earlier than August 1st as sanctioned by the Ohio High School Athletic Association and continues through the date of the last official game of the 2024 season, including playoffs. Other aspects of coverage will not commence until the official first day of school.

TERMINATION OF POLICY/CERTIFICATE OF COVERAGE: Policyholder: The Policy is issued for the agreed upon term of coverage and is non-renewable. Certificateholder: 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.

EXCESS PROVISION: All Covered Charges will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance covers the Insured person.

EXCLUSIONS

THE POLICY DOES NOT COVER: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are 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 sustained while violating or attempting to violate any duly enacted law; (4) Injury by acts of war, whether declared or not; (5) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four-wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained while participating in or practicing for senior high interscholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

IMPORTANT INFORMATION

1. Treatment must begin within thirty (30) days of Accident.
2. Expense must be incurred within fifty-two (52) weeks of Accident.
3. Written proof of loss must be furnished within ninety (90) days of Accident.
4. No refunds are available.

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.

2024-25

POLICY BENEFITS AND PREMIUMS

All Maximum amounts are per Injury except as specifically stated

Injury means bodily injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Covered Person's coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries are considered a single Injury.

COVERAGE AND BENEFITS	LOW OPTION	HIGH OPTION
Maximum Benefit Amount Per Injury	$25,000.00	$25,000.00
Deductible	$0.00	$0.00
Hospital Room and Board and general nursing care, limited to a maximum of	$150.00/day	$300.00/day
Hospital Miscellaneous Expense, limited to a maximum of	$1,000.00	$2,000.00
Hospital Emergency Care, limited to a maximum of	$150.00	$300.00
Orthopedic Appliances furnished by the Hospital, limited to a maximum of	$100.00	$200.00
Doctor's fees for surgery, limited to a maximum of	$1,500.00	$3,000.00
Anesthesia Services	100% of Reasonable & Customary	100% of Reasonable & Customary
Non-Surgical Doctors' Visits, including Physical Therapy Physical Therapy is limited to a maximum benefit of 3 visits.	$25.00	$50.00
Dental Treatment, per tooth (for Injury to Sound, Natural Teeth), limited to Up to a maximum of	$200.00 $600.00	$400.00 $1,200.00
Imaging procedures, including X-rays and interpretation, limited to a maximum of amount of	$100.00	$200.00
MRI/CAT Scan, up to a maximum benefit of	$125.00	$250.00
Ambulance Expense, limited to a maximum of	$100.00	$200.00
Loss of Life	$2,000.00	$2,000.00
Loss of One Hand or One Foot or Entire Sight of Both Eyes	$1,000.00	$1,000.00
Loss of both Hands or Feet	$10,000.00	$10,000.00
PREMIUMS (ONE-TIME PAYMENT)	**LOW OPTION**	**HIGH OPTION**
SCHOOL-TIME ACCIDENT COVERAGE Students — Grades K - 6 Grades 7 - 12	 $23.00 $37.00	 $46.00 $74.00
24-HOUR-A-DAY ACCIDENT COVERAGE Students — Grades K - 6 Grades 7 - 12	 $79.00 $91.00	 $158.00 $182.00
OPTIONAL FOOTBALL ONLY ACCIDENT COVERAGE Per Player — Grades 10 - 12 (including grade 9 if playing or practicing with grades 10 through 12)	$129.00	$258.00

GTL GUARANTEE TRUST LIFE 2024-2025 STUDENT ACCIDENT INSURANCE PLANS

- 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 expense.
- 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), its representatives or school officials (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	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 Only Accident 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.
Football premium covers football only.

To file a claim: Report accidents to the school. Forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Complete proof of loss and accumulated bills must be received by Guarantee Trust Life Insurance Company 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.

What's Covered? *Up to* $25,000.00 as described under Coverage and Benefits *for:*

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS FROM ACCIDENTAL BODILY INJURY RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES
- COVERED MEDICAL EXPENSE WHICH BEGINS WITHIN 30 DAYS OF THE ACCIDENT AND IS INCURRED WITHIN 52 WEEKS OF THE ACCIDENT

COVERAGE AND BENEFITS

BENEFITS ARE PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		LOW OPTION	HIGH OPTION
HOSPITAL ROOM AND BOARD AND GENERAL NURSING CARE	Per day	**$150**	**$300**
HOSPITAL MISCELLANEOUS EXPENSE		**$1,000**	**$2,000**
HOSPITAL EMERGENCY CARE		**$150**	**$300**
DOCTOR'S FEES FOR SURGERY	Limited to a maximum of	**$1,500**	**$3,000**
ANESTHESIA SERVICES		**100% of Reasonable & Customary**	
AMBULANCE EXPENSE		**$100**	**$200**
DOCTORS' VISITS **Non-surgical** Including Physical Therapy	Per visit	**$25**	**$50**
	Physical Therapy, per visit	**$25**	**$50**
	Maximum number of visits per Injury	**3**	**3**

BENEFITS PER INJURY		LOW OPTION	HIGH OPTION
IMAGING PROCEDURES	Including X-rays and interpretation	**$100**	**$200**
MRI/CAT Scan		**$125**	**$250**
ORTHOPEDIC APPLIANCES	Furnished by the Hospital	**$100**	**$200**
DENTAL TREATMENT	For Injury to Sound, Natural Teeth, per tooth	**$200**	**$400**
	Up to a maximum of	**$600**	**$1,200**
ACCIDENTAL DEATH AND DISMEMBERMENT Only one of these benefits, the largest, will be payable in addition to other benefits shown	Caused by an Injury and occurring within 365 days of the covered Accident		
	ACCIDENTAL DEATH	**$2,000**	
	DISMEMBERMENT		
	Loss of One Hand or One foot	**$1,000**	
	Loss of the Entire Sight of Both Eyes	**$1,000**	
	Loss of Both Hands or Feet	**$10,000**	

Injury means bodily Injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Insured's cover-age under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

EXCLUSIONS - THE POLICY DOES NOT COVER: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are 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 sustained while violating or attempting to violate any duly enacted law; (4) Injury by acts of war, whether declared or not; (5) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four- wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained while participating in or practicing for senior high interscholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

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.

Administered by: **STUDENT PROTECTIVE AGENCY,** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544
Underwritten and claims paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL),** 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

2024-2025 School Year Enrollment Form

GTL | Guarantee Trust Life

PLEASE PRINT CLEARLY

One Time Annual Payment		
OPTIONS	**Low Option**	**High Option**
24-Hour-A-Day Plan		
Students Grades K-6	❑ $79	❑ $158
Students Grades 7-12	❑ $91	❑ $182
School-Time Plan		
Students Grades K-6	❑ $23	❑ $46
Students Grades 7-12	❑ $37	❑ $74
Optional Football Coverage (Grades 10-12, including grade 9 if playing with 10-12) 2024 Season Only Per Player	❑ $129	❑ $258

TOTAL $_____ (Please do not send cash)

Make check payable to your local agency

No Refunds are available

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

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:

STUDENT PROTECTIVE AGENCY
300 Coshocton Avenue
Mount Vernon, OH 43050

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

GTL GUARANTEE TRUST LIFE — PLANES DE SEGUROS DE ACCIDENTES PARA ESTUDIANTES 2024-25

- ¡Los accidentes son comunes! Cuando le suceden a su hijo, alguien debe pagar esos costos.
- Aquí le presentamos planes de seguros contra accidentes para cubrir a su hijo las 24 horas del día (Plan de 24 horas) o en la escuela (Plan de Tiempo Escolar).
- Estos planes ofrecen beneficios para ayudar a cubrir el costo de los gastos médicos y hospitalarios.
- Si tiene otro Seguro, estos planes pueden ayudar a compensar los deducibles y coaseguro de dichos planes.
- Si no tiene otro seguro, estos planes proporcionarán cobertura básica.
- Cualquier beneficio pagable por esta póliza como resultado de un servicio médico, quirúrgico, dental, hospitalario o de enfermería será pagado directamente al hospital o a la persona que proporcione dichos servicios, a menos que se proporcione prueba del pago completo. .

24-Horas	Tiempo Escolar	DETALLES IMPORTANTES SOBRE LA PROTECCIÓN
✓	✓	Entra en vigor en la fecha en que Guarantee Trust Life Insurance Company (GTL) sus representantes o funcionarios escolares reciben el pago de la prima (pero no antes del primer día de clases). Los estudiantes que participen en prácticas preescolares o practiquen deportes interescolares autorizados por la Asociación Atlética de Escuelas Secundarias de Ohio estarán cubiertos a partir de la misma fecha del pago de la prima, pero solo mientras participen en sesiones de práctica o juego. Otros aspectos de la cobertura no entrarán en vigor hasta el primer día de clases regulares.
✓	✓	Proporciona cobertura durante las horas en las cuales la escuela está en actividades regulares.
✓		Proporciona cobertura las 24 horas del día.
✓	✓	Ofrece cobertura durante el tiempo necesario para el viaje entre la casa del asegurado y el comienzo o final de clases regulares.
✓	✓	Brinda cobertura mientras participa (o asiste) a actividades organizadas, patrocinadas y supervisadas por la escuela. También se proporciona cobertura para viajar directamente hacia y desde tales actividades en un Vehículo Designado provisto por la escuela.
	✓	La cobertura expira al terminar el ciclo escolar regular. (La cobertura se extenderá mientras se asista a clases académicas para obtener créditos en el verano, cuando las actividades escolares son patrocinadas y supervisadas exclusiva y únicamente por la escuela, no se proporcionará cobertura para el transporte de y hacia las clases.)
✓		La cobertura continúa sin interrupción todo el verano, hasta que la escuela inicie el siguiente ciclo escolar.

La cobertura opcional de fútbol comienza en la fecha en que GTL, sus representantes o los oficiales de la escuela reciban la prima, pero no antes de la primera fecha oficial de entrenamiento, y continúa hasta la fecha del último partido oficial de la temporada actual, incluyendo las eliminatorias.
La prima de fútbol cubre solo fútbol.

Para presentar un reclamo: reporte los accidentes a la escuela. Los formularios se proporcionarán a través de la oficina del director (durante las vacaciones, comuníquese con los administradores del plan). La prueba completa de la pérdida y las facturas acumuladas debe ser recibida por Guarantee Trust Life Insurance Company dentro de los 90 días posteriores al accidente.

COBERTURA DE ACCIDENTES LAS 24 HORAS DEL DÍA

¡Protección las 24 horas para cada accidente cubierto!

Proteja a su hijo durante todo el año escolar y se extiende durante el verano - hasta que la escuela inicie nuevamente.

Su hijo estará cubierto EN TODO EL MUNDO, LAS 24 HORAS DEL DÍA.

Esto incluye accidentes cubiertos: ✎ En el hogar ✎ Al jugar ✎ En la escuela

✎ Durante las vacaciones ✎ Al acampar, explorar, etc. ✎ Durante viajes cubiertos

✎ Mientras participe en deportes, excepto aquellos que estén excluidos específicamente o para los cuales se requiere cobertura opcional*

*Vea las OPCIONES para descubrir cualquier cobertura opcional para deportes.

COBERTURA DE ACCIDENTES DURANTE EL TIEMPO ESCOLAR

Ayuda a proteger a su hijo mientras asiste a clases regulares. Incluye cobertura para los viajes directos hacia y desde su residencia para asistir a clases regulares, durante el tiempo de viaje requerido, pero durante no más de una hora antes o después de las clases regulares. El tiempo de viaje en el autobús escolar se extiende por cualquier tiempo adicional necesario. Además, se ofrece cobertura mientras se participa en (o se asiste) a actividades cubiertas organizadas, patrocinadas y supervisadas exclusivamente por la escuela y los empleados de la escuela, incluido el viaje directo hacia y desde la actividad en un Vehículo designado proporcionado por la escuela y supervisado únicamente por los empleados de la escuela. Es posible que se requiera cobertura opcional para los deportes interescolares. Consulte OPCIONES para conocer la cobertura deportiva opcional disponible, si corresponde.

RESCISIÓN DE LA PÓLIZA/CERTIFICADO DE COBERTURA: La Póliza se emite por el plazo de cobertura acordado y no es renovable. La cobertura terminará en la fecha que ocurra primero entre: (1) la fecha de terminación de la póliza; o (2) la fecha en que el asegurado deja de ser miembro de los equipos deportivos del titular del seguro; o (3) el último día de actividad deportiva programada regularmente; o (4) la fecha en que el asegurado deja de ser una persona elegible; o (5) el final del período por el cual se ha pagado cualquier prima aplicable. Tenemos derecho a cancelar la cobertura de cualquier asegurado que presente un reclamo fraudulento bajo la póliza.

¿Qué cubren? *Hasta un* máximo de $25,000 de acuerdo a la descripción de Cobertura y Beneficios:

- Accidentes que ocurran durante la vigencia de la cobertura.
- Pérdida debido a lesiones accidentales que resulten directa e independientemente de todas las otras causas.
- Gastos médicos cubiertos que comienzan dentro de los 30 días posteriores al accidente e incurridos dentro de las 52 semanas posteriores al accidente.

COBERTURA Y BENEFICIOS

Los beneficios se pagan *hasta el* monto en dólares especificado a continuación

BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta
ALOJAMIENTO Y COMIDA EN HOSPITAL Y CUIDADOS GENERALES DE ENFERMERÍA	Por día	$150	$300
GASTOS VARIOS DE HOSPITAL		$1,000	$2,000
ATENCIÓN DE EMERGENCIA HOSPITALARIA		$150	$300
HONORARIOS MÉDICOS POR CIRUGÍA	Limitado a un máximo de	$1,500	$3,000
SERVICIOS DE ANESTESIA		100% de lo razonable y usual	
GASTOS DE AMBULANCIA		$100	$200
CONSULTAS MÉDICAS **No quirúrgicas** Incluye terapia física	Por consulta	$25	$50
	Terapia física por consulta	$25	$50
	Número máximo de consultas por lesión	3	3

BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta
PROCEDIMIENTOS DE IMAGENOLOGÍA	Incluye radiografías e interpretación	$100	$200
EXPLORACIÓN POR MRI/TAC		$125	$250
APARATOS ORTOPÉDICOS	Provistos por el hospital	$100	$200
TRATAMIENTO DENTAL	Para Lesiones en dientes naturales sanos, por diente	$200	$400
	Hasta un máximo de	$600	$1,200
MUERTE ACCIDENTAL Y DESMEMBRAMIENTO Solo uno de estos beneficios, el más grande, será pagadero además de otros beneficios que se mencionan	Causado por una lesión y ocurrido dentro de los 365 días posteriores al accidente cubierto		
	MUERTE ACCIDENTAL	$2,000	
	DESMEMBRAMIENTO		
	Pérdida de una mano o un pie	$1,000	
	Pérdida de la vista completa de ambos ojos	$1,000	
	Pérdida de ambas manos o pies	$10,000	

Una Lesión es toda Lesión corporal originada en un Accidente que resulte directa e independientemente de una enfermedad, dolencia corporal o cualquier otra causa; que única, directa e independientemente de todas las demás causas, resulte en gastos médicos; que ocurra después de la fecha de entrada en vigor de la cobertura del Asegurado por la Póliza; y que ocurra mientras la Póliza esté en vigor. Todas las lesiones sufridas en cualquier Accidente, entre ellas todas las condiciones relacionadas y los síntomas recurrentes de estas lesiones, son consideradas una sola Lesión.

EXCLUSIONS - LA PÓLIZA NO CUBRE: (1) tratamientos, servicios o suministros que no sean Médicamente necesarios; no recetados por un Médico como necesarios para tratar una Lesión; de naturaleza experimental/de investigación; recibidos sin cargo ni obligación legal de pago; recibidos de personas empleadas o contratados por el Titular de la Póliza o cualquier Miembro de la Familia, salvo que se especifique lo contrario; o no catalogados específicamente como Cargos Cubiertos en la Póliza; (2) lesiones autoinfligidas intencionalmente; (3) lesiones sufridas al violar o intentar violar cualquier ley debidamente promulgada; (4) lesiones por actos de guerra, declarada o no; (5) lesiones recibidas durante un viaje o vuelo, excepto en el caso en el que se viaje como pasajero que paga una tarifa en una aerolínea comercial regular; (6) lesiones cubiertas por la Ley de Compensación al Trabajador o la Ley de Enfermedades Ocupacionales; (7) tratamientos de enfermedades, dolencias o infecciones, excepto infecciones que resulten de una Lesión accidental o infecciones que resulten de la ingestión accidental, involuntaria o no intencional de una sustancia contaminada; (8) hernias, de cualquier tipo; (9) lesiones sufridas en peleas o reyertas, excepto en defensa propia; (10) suicidio o intento de suicidio; (11) cualquier sanción impuesta por otro seguro o plan válido y cobrable por no seguir los procedimientos del plan; (12) pérdida resultante del uso de cualquier droga o agente clasificado como narcótico, psicolítico, psicodélico, alucinógeno o que tenga una clasificación o efecto similar, a menos que sea recetado por un Médico; (13) lesiones sufrida al operar, viajar en, subirse o bajarse de cualquier vehículo recreativo de dos, tres o cuatro ruedas con motor, motonieve o vehículo todo terreno (ATV, por sus siglas en inglés); (14) lesiones sufridas mientras se participa en o practicaba fútbol americano interescolar de escuela preparatoria, incluido el grado 9 si jugaba en el grado 10 o superior, incluido el viaje, a menos que se haya comprado una cobertura opcional; (15) cirugías cosméticas o plásticas, excepto cirugías reconstructivas en una parte lesionada del cuerpo; (16) tratamientos en cualquier Administración de Veteranos u Hospital federal, excepto si existe una obligación legal de pago; (17) pérdida resultante de estar legalmente intoxicado o bajo la influencia del alcohol según lo definido por las leyes del estado en el que ocurre la Lesión; (18) tratamientos odontológicos, salvo que se indique específicamente; (19) servicios de un cirujano asistente o Doctor cuando se realiza una cirugía; (20) anteojos, lentes de contacto, exámenes oculares de rutina o recetas para los mismos; (21) medicamentos recetados, muletas, aparatos ortopédicos, miembros artificiales, etc., salvo que se indique específicamente.

El seguro Blanket contra Accidentes se emite según la serie de formularios de póliza GP-2030, GP-2020 o GP-1200 por Guarantee Trust Life Insurance Company, Glenview, IL. La póliza tiene exclusiones, limitaciones, reducciones de beneficios y condiciones de elegibilidad y terminación. Sujeto a disponibilidad y variabilidad estatal. La Póliza prevalecerá en caso de conflicto entre la Póliza y este folleto. Para obtener detalles completos de la cobertura, comuníquese con el agente que administra el programa.

Administrado por: **STUDENT PROTECTIVE AGENCY,** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

Pagadas por: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL),** 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

FORMULARIO DE INSCRIPCIÓN PARA EL AÑO ESCOLAR 2024-25

SOLO UN PAGO POR AÑO		
OPCIONES	Opción Baja	Opción Alta
PLAN DE 24 HORAS AL DÍA		
ESTUDIANTES DE GRADOS K-6	❑ $79	❑ $158
ESTUDIANTES DE GRADOS 7-12	❑ $91	❑ $182
PLAN DE TIEMPO ESCOLAR		
ESTUDIANTES DE GRADOS K-6	❑ $23	❑ $46
ESTUDIANTES DE GRADOS 7-12	❑ $37	❑ $74
COBERTURA OPCIONAL DE FÚTBOL (GRADOS 10-12, INCLUYENDO GRADO 9 SI SE JUEGA EN 10-12) TEMPORADA 2024 SOLO POR JUGADOR	❑ $129	❑ $258
TOTAL $_____ Por favor no envíe efectivo		

EXTIENDA EL CHEQUE A FAVOR DE SU AGENCIA LOCAL

NO HAY REEMBOLSOS DISPONIBLES

GTL GUARANTEE TRUST LIFE

POR FAVOR ESCRIBIR CLARAMENTE:

NOMBRE DEL ESTUDIANTE _____
PRIMER NOMBRE INICIAL 2o. NOMBRE APELLIDO

FECHA DE NACIMIENTO _____ **MASCULINO** ❑ **FEMENINO** ❑
MES DÍA AÑO

DISTRITO ESCOLAR _____ **ESCUELA** _____

GRADO _____ **DIRECCIÓN DEL ESTUDIANTE** _____

CIUDAD _____ **ESTADO** _____ **CÓDIGO POSTAL** _____

TELÉFONO # _____ **FECHA DE INSCRIPCIÓN** _____

CORREO ELECTRONICO DEL PADRE O TUTOR _____

_____
Nombre Del Padre O Tutor (En Letra De Molde)

_____
FIRMA DEL PADRE O TUTOR

POR FAVOR RECUERDE:

COMPLETAR EL FORMULARIO DE INSCRIPCIÓN Y MARCAR EL PLAN Y LAS OPCIONES QUE DESEA.

EMITIR SU CHEQUE O GIRO POSTAL (POR FAVOR NO ENVÍE EFECTIVO) POR EL TOTAL A PAGAR DE ACUERDO A LO INDICADO.

Envíe su formulario de inscripción con su cheque o el giro postal a:

STUDENT PROTECTIVE AGENCY
300 Coshocton Avenue
Mount Vernon, OH 43050

TENGA EN CUENTA: SU CHEQUE CANCELADO ES SU RECIBO. SI EL CHEQUE CANCELADO NO SE RECIBE DENTRO DE LOS 60 DÍAS, COMUNÍQUESE CON EL ADMINISTRADOR DE SU PLAN.

NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the Organization **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Group or Association name on the claim form. Also, the "Authorization To Permit Use and Disclosure of Health Information" must be signed.

- Your 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 balanced 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) **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. **Please note**: This is not necessary if you have purchased a "Primary" plan through GTL that pays regardless of other insurance payments.

- 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
P.O. Box 1148
Glenview, Illinois 60025

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.

- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.

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

IMPORTANT:
Please take note that your claim will result in a processing delays as the result of not providing us with the following: the completed claim forms, 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) 622-1993.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

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

GUARANTEE TRUST LIFE INS. CO.
P.O. Box 1148
Glenview, IL 60025
(800) 622-1993

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 Co. 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

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 in 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 _____

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? ☐NO ☐YES
IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:
Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: Father _____ Mother _____
Employer's Name: _____ _____
Employer's Address. _____ _____

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

DATE: _____ SIGNATURE: _____
(Claimant, or Parent if Claimant is a minor)

Note: ***Your State Insurance Department requires us to notify you that:*** 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

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

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. 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. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. 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 my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company 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. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company 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. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

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.

_____

(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