

STUDENT ACCIDENT INSURANCE

Select the insurance plan to help offset
the cost of medical care.....

- SCHOOL-TIME ACCIDENT COVERAGE
- FULL-TIME (24 HOUR) ACCIDENT COVERAGE
- DENTAL (24 HOUR) ACCIDENT OPTION
- VARSITY FOOTBALL INSURANCE PLAN
- PROVIDES COVERAGE FOR UIL ACTIVITIES/ INTERSCHOLASTIC SPORTS
- PRIMARY COVERAGE



SEE DETAILS INSIDE - Dental Accident Plan Up to \$5,000 for \$9

Enrollment Form Enclosed

APPROVED BY YOUR SCHOOL FOR GRADES PK-12



Marketed by
David Cates
The Brokerage Store
4114 Pond Hill Road • Suite 100
San Antonio, TX 78231
210-366-4800 or Toll Free 800-366-4810

Y-1745(TX)(2013)

Premiums & Coverage Options

POLICY FORMS GH-2200 (TX)

One Time Annual Premiums



School Time Coverage PK-12

(does not include UIL Activities/ Interscholastic Sports Coverage)

\$25

Protects the student while: a) attending regular school sessions, b) participating in or attending school-sponsored and supervised extra-curricular activities, c) traveling directly to and from school for regular school sessions, and while traveling to and from school-sponsored and supervised activities in school provided transportation. DOES NOT cover participation in UIL Activities for students in the 7th grade or above. Coverage ends the first day of school next year.



Full Time Coverage PK-12

(does not include UIL Activities/ Interscholastic Sports Coverage)

\$105

Covers the student 24 hours a day until school starts next year. Includes coverage while at home, at school, weekends and summer vacation. DOES NOT cover participation in UIL Activities for Students in the 7th grade or above.



School Time Coverage PK-12 (includes UIL Activities/ Interscholastic Sports Coverage except Varsity Football Grades 10 - 12 and Grades 7-9 if they practice or play with Grades 10-12)

\$115

In addition to School-Time Coverage shown above, the UIL Activities Coverage protects the student while practicing for or participating in school-sponsored and supervised UIL Activities including travel in school provided transportation, for grades 7-12. It DOES NOT cover Varsity Football for grades 10-12 and grades 7-9 if they practice or play with grades 10-12. Includes Spring and Summer football exclusively sponsored and supervised by the Policyholder, if football coverage was not purchased during the regular football season.



Full Time Coverage PK-12 (includes UIL Activities/ Interscholastic Sports Coverage except Varsity Football Grades 10 - 12 and Grades 7-9 if they practice or play with Grades 10-12)

\$195

In addition to the Full-Time Coverage shown above, the UIL Activities Coverage protects the student while practicing or participating in school-sponsored and school-supervised UIL Activities including travel in school-provided transportation for grades 7-12. It DOES NOT cover Varsity Football for grades 10-12 and grades 7-9 if they practice or play with grades 10-12. Includes Spring and Summer football exclusively sponsored and supervised by the Policyholder, if football coverage was not purchased during the regular football season.



Varsity Football Coverage (Grades 10 - 12 and Grades 7-9 if they practice or play with Grades 10-12)

\$325

Protects the student while practicing for or participating in school-sponsored and school supervised interscholastic football including travel in school-provided transportation. Includes Spring and Summer football exclusively sponsored and supervised by the Policyholder.



Extended Dental Coverage PK-12

\$9

Provides benefits up to a maximum of \$5,000 for any dental injury. Covers the student 24 hours a day until school starts next year. Treatment must begin within 180 days from the date of the injury and must be performed within one year from the date of injury. However, if within the one year period following the date of injury the student's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the policy pays the estimated cost of such deferred treatment, but not to exceed \$200 for each tooth. Benefits for prosthesis are limited to \$500 per injury, including procedures performed to install them. Dental prosthesis includes, but is not limited to: crowns, dentures, bridges, and implants. Extended Dental does not cover treatment for orthodontics, dental disease, or expenses that exceed the dental prosthesis maximum benefit limit.

The Medical Benefits and Exclusions apply to Coverage Options listed above.

HOW TO ENROLL

1. Select the coverage you want from the options listed above. Complete the Enrollment envelope and enclose your check made payable to: STUDENT ASSURANCE SERVICES, INC. or complete the credit card payment information form. Premium cannot be prorated. Please write the name of the student on your check.
2. You can also enroll online at the Student Assurance Services, Inc. website www.sas-mn.com. The online form is available under the K-12 School Look-up.
3. Be sure to retain this brochure and a copy of the premium payment as proof of insurance. You will not receive a policy or ID card. The master policy is issued to your school.

Return your payment or credit card information form with the requested enrollment information to: Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082.

EFFECTIVE AND EXPIRATION DATES

Coverage becomes effective the later of: the Master Policy Effective Date; or 12:01A.M. following the date the envelope containing the enrollment form and premium payment is postmarked by the U.S. Postal Service, or for on-line enrollment 12:01AM following the date the proper premium is received by the Plan Administrator, but not prior to August 1. All Coverages expire on the Master Policy Expiration Date, which is midnight 12:00am July 31 of the current school year.

MEDICAL BENEFITS (What the Insurance Plan Pays) - When injury covered by this policy results in treatment by a licensed physician within 180 days from the date of injury, the Company will pay the usual and customary (U&C) charges incurred for necessary services and supplies as listed below, for expenses actually incurred within one year from the date of injury up to a Maximum Medical Benefit of \$25,000 per injury. This policy will pay benefits regardless of Other Valid Coverage. Unless otherwise stated all amounts listed below are per injury.

- A. IN-PATIENT BENEFITS** **All Amounts Listed Below are Per Injury**
1. Hospital Room and Board..... Semi-private Room Charges
 2. Intensive Care (in lieu of Hospital Room and Board)..... 1.5 X Semi-private Room Charges
 3. Hospital Miscellaneous Services (All Charges except Room & Board) U&C, first day up to \$1,000, then up to \$500 per day; maximum \$5,000
 4. Physician's Non-Surgical Visits (does not include Physical Therapy;... not paid day of surgery)..... U&C, first day of treatment up to \$50, subsequent visits up to \$40; maximum 10 visits
 5. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith)..... Included in Hospital Misc. Benefit
 6. X-ray and Radiology Services Included in Hospital Misc. Benefit
 7. Registered Nurse..... U&C

B. OUT-PATIENT SURGERY BENEFITS

1. Day Surgery (Facility Charge), room supplies and all other expenses for out-patient surgery U&C, up to \$2,000

C. OTHER OUT-PATIENT BENEFITS

1. Hospital Emergency Room Charges U&C, up to \$300
2. X-ray and Radiology Services U&C; up to \$250 Facility; \$50 Reading
3. CAT Scans, MRI and Bone Scans U&C; up to \$750 Facility; \$50 Reading
4. Laboratory Services U&C, up to \$100
5. Physician's Non-Surgical Visits (not paid day of surgery) .. U&C, up to \$50 per visit; 10 visit maximum
6. Emergency Room Physician's Non-Surgical Care U&C, up to \$150
7. Orthopedic Appliances (when prescribed by a physician for healing) U&C, up to \$500
8. Shots and Injections (within 24 hours of an injury) U&C, up to \$50
9. Prescription Drugs U&C, up to \$50
10. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits) U&C, up to \$50 per visit; maximum 5 visits
11. Ambulance Service (Air or Ground)..... U&C, up to \$1,000
12. Eyeglass Replacement (if medical treatment is also received for a covered injury) U&C, up to \$200
13. Durable Medical Equipment (Post-Surgical Only) U&C, up to \$100

D. OTHER PHYSICIAN SERVICES

1. Dental Treatment (in lieu of all other medical benefits, including x-rays of sound & natural teeth) U&C, up to \$200 per tooth
2. Physician's Surgical Care (In-Patient or Out-patient) Only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession..... U&C up to \$2,500
3. Assistant Surgeon Charges (In-Patient or Out-patient) 25% of Surgery Allowance
4. Anesthetist Charges (In-Patient or Out-patient)..... 25% of Surgery Allowance

E. MOTOR VEHICLE INJURY Same as any Injury, up to \$1,000

F. OTHER BENEFITS - Heat Stroke and Heat Exhaustion will be covered as any other accident.

G. ACCIDENTAL DEATH AND DISMEMBERMENT

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

Loss of Life.....\$2,000	Double Dismemberment.....\$10,000
Loss of an Eye.....\$2,000	Single Dismemberment.....\$ 2,000

EXCLUSIONS (What the Plan DOES NOT Pay)

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are payable under Workers' Compensation or Employer's Liability Laws.
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Replacement of contact lenses, hearing aids or prescriptions or examinations thereof.
5. The participation, practice or play of UIL activities including travel to or from such activity, practice, or play for students in the 7th grade or above, unless such premium is paid.

THE POLICY CONTAINS A PROVISION LIMITING COVERAGE TO USUAL AND CUSTOMARY CHARGES. THIS LIMITATION MAY RESULT IN ADDITIONAL OUT-OF-POCKET EXPENSES FOR THE INSURED.



WHY SHOULD MY STUDENT BE COVERED BY THIS INSURANCE?

As a service to its students, your school is offering an opportunity to enroll in a student accident insurance plan administered by Student Assurance Services, Inc. Participation in this plan is voluntary. This brochure describes several coverage and premium options. Please review the entire brochure before making a decision to purchase this insurance or contact us directly with your questions.

WHY IS THE SCHOOL PARTICIPATING IN THIS OFFERING?

Students are particularly susceptible to accidental injury. This plan will help provide coverage for expenses that are not covered by your family medical or dental coverage.

WHAT KIND OF INSURANCE IS THIS?

This is accidental bodily injury insurance; it covers accidental bodily injury occurring while the coverage is in force. Medical illnesses such as ear infections or sore throats are not covered.

WHO SHOULD CONSIDER BUYING THIS INSURANCE?

1. All families with no other health coverage.
2. Families with other medical or dental coverage having deductibles or copays. You can benefit because there are no deductibles or copays in our policy.

HOW TO FILE A CLAIM

1. Report school related injuries immediately to the school office;
2. Obtain a claim form from the school;
3. Follow ALL claim form instructions, attach all itemized bills and send to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196 • STILLWATER, MN 55082-0196
4. Questions about claims will be answered immediately by calling (800) 328-2739 or (651) 439-7098. The claims staff is available 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday.

NOTE: Student must be treated by a licensed physician within 180 days of the date of the injury. Proof of claim should be submitted within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills should be submitted within 90 days from the date of treatment or reasonable time thereafter not to exceed one year. We are responsible only for expenses incurred within one year.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Accident Insurance Policy Form GH-2200 (and any state specific), and any applicable endorsement(s) Extended Dental Coverage GHE-2201 (and any state specific). This policy is considered term accident insurance and is non-renewable. This product may not be available in all states and is subject to individual state regulations. The Master Policy is issued to the School District/School.

**HAVE QUESTIONS?
CALL US TOLL FREE AT
(800) 366-4810 OR (210) 366-4800**



IT IS NOT THE INTENT OF THE POLICY TO PROVIDE BENEFITS FOR AN EXISTING MEDICAL PROBLEM. A re-injury will not be covered if the insured has received treatment within a period of 180 days prior to the effective date of the policy.

ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE

Please fill out the information on the enrollment tear-off, select the desired coverage, and return with the correct premium or complete credit card information as soon as possible.

NOTE - You can purchase this insurance anytime between the Master Policy effective and expiration date for authorized UIL Activities that begin and end during the current school year.

REMEMBER TO FILL-OUT ALL REQUESTED INFORMATION AND RETURN ALONG WITH YOUR PREMIUM OR CREDIT CARD PAYMENT INFORMATION TO:
 Student Assurance Services, Inc.
 P.O. Box 196
 Stillwater, MN 55082-0196

In order to make coverage effective, Please return this completed enrollment form as soon as possible.

DATE RECEIVED _____

ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE		COVERAGE PLANS	One Time Annual Premiums
SECURITYLIFE <small>INSURANCE COMPANY OF AMERICA MINNETONKA, MINNESOTA</small>	↑ STUDENT'S LAST NAME ↑ (one letter in each box) _____ _____	School Time Coverage (does not include UIL Activities / Interscholastic Sports Coverage)	<input type="checkbox"/> \$ 25
	STUDENT'S FIRST NAME _____ M.I. _____ Please Print Address _____ _____ _____ (City) _____ (State) _____ (Zip)	Full Time Coverage (does not include UIL Activities / Interscholastic Sports Coverage)	<input type="checkbox"/> \$ 105
	Email Address _____ Name of School _____ Name of District _____ Student's Age _____ Grade _____ Phone _____	School Time Coverage (includes UIL Activities/Interscholastic Sports Coverage, does not include Varsity Football)	<input type="checkbox"/> \$ 115
	X _____ GH A-2203(GEN) (Signature of Parent or Guardian) _____ (Date) _____	Full Time Coverage (includes UIL Activities/Interscholastic Sports Coverage; does not include Varsity Football)	<input type="checkbox"/> \$ 195
		Varsity Football Coverage (grades 10-12 and grades 7-9 if they practice or play with grades 10-12)	<input type="checkbox"/> \$ 325
		Extended Dental Coverage (PK-12)	<input type="checkbox"/> \$ 9
DO NOT SEND CASH		TOTAL PREMIUM	
Make Checks payable to: STUDENT ASSURANCE SERVICES, INC. *Please write student's name on the front of check. NO REFUNDS			
NOTE: To apply for Student Accident Insurance, either complete this enrollment form or enroll online under K-12 School Look-up at: www.sas-mn.com Y-1745(TX)(2013)			

STUDENT ACCIDENT INSURANCE CREDIT CARD PAYMENT

INDICATE PREMIUM SELECTED AND COMPLETE THE REQUESTED ENROLLMENT INFORMATION FOUND ON THE REVERSE SIDE OF THIS FORM.
There is a \$5.00 Processing Fee added to ALL Credit Card Transactions

Please charge \$ _____ + \$5.00 Processing Fee = \$ _____ to the following credit card:
 VISA®, MasterCard®, or Discover®

Credit Card Number	Security Code (on back of card, 3 digits)	Card Expiration Date	
_____ _____	_____ _____	(Month) (Year) _____ - _____	Credit card billing will state: "Student Assurance Services, Inc."

Print Cardholder Name _____ Date ____ / ____ / ____
 Cardholder Signature _____
 Cardholder Address _____
 _____ (Street) _____ (City) _____ (State) _____ (Zip)
 Telephone Number (_____) _____ - _____

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