UP TO $1,000,000 VOLUNTARY STUDENT ACCIDENT MEDICAL INSURANCE PROTECTION





2024-2025 SCHOOL YEAR

Underwritten By:
AXIS Insurance Company

IMPORTANT NOTICE

This Brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in Pennsylvania under form number BACC-001-0909-PA . Complete details are found in the policy on file at your school's office. The policy is subject to exclusions and limitations and is governed by the laws of the state in which it was issued. Please keep this information for your reference. THIS INSURANCE DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES.

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STUDENT ACCIDENT INSURANCE 2024-2025 SCHOOL YEAR

A reminder to the parents of students attending school in our School District. Our school district **does not carry medical insurance on students**. We do provide parents with the opportunity to select a primary accident plan for students.

Student accident insurance can help you reduce out-of-pocket expenses, since many group insurance plans no longer pay full hospital and medical expenses and may require a high deductible or co-insurance. There are two plans available for your consideration:

PLAN #1 →

School Time Coverage

Costs $27 per student

Covers an injury occurring while attending school sponsored and supervised activities such as plays, assemblies, class trips, interscholastic sports (other than Sr.high football), intramural sports, gym and physical education classes. Coverage includes travel to and from school and activities.

PLAN #2 →

24 Hour Coverage

Costs $98 per student

Covers your student for all of the above, plus accidents occurring away from school, in the evenings and on the weekends, vacations, etc.

Please see the attached brochure for a complete description of the plans and the various coverage options.
If you have any questions, please call Sportunderwriters.com at 1 (833) 636-3939.

These plans should be considered in conjunction with your primary insurance coverage.

PLEASE DO NOT SEND CASH!! A completed application (found on page seven of the attached brochure) should be returned by mail with a check or money order for the correct premium, directly to:

Sportunderwriters.com Inc
2047 Saranac Avenue, Suite 201
Lake Placid, NY 12946

DO NOT RETURN THE APPLICATION & PAYMENT TO YOUR STUDENT'S SCHOOL

This insurance can be purchased anytime during the school year.

Parents enrolling more than one child MUST complete an application for each child/student being enrolled and mail in separate envelopes to the address above.Your cancelled check or money order receipt is your proof of payment.

BEST BUY
24-HOUR COVERAGE

Around-the-clock accident coverage for your child at any time. Insurance Protection during vacations, weekends and school days.

24-Hour Coverage is your best buy because it is not limited to school connected accidents but also covers accidental Injury at home or away. ANY COVERED ACTIVITY - ANYTIME - ANYWHERE. Continuous Insurance protection from the effective date to the opening of the next school term.

Coverage becomes effective on the date the Application and Premium are received by the school. Once effective, coverage continues until the first day of school in the following year or until the policy with the school expires, whichever occurs first. This coverage is subject to the terms and conditions stated in the policy.

SCHOOL TIME ACCIDENT COVERAGE

Insurance coverage for the hours and days when school is in session and while attending school sponsored and supervised activities.

- During school year
- School supervised activities
- On the school premises
- Class trips
- Travel to and from school

This coverage is subject to the terms and conditions stated in the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT OR LOSS OF SIGHT

When Injury results in an Insured's death, the Company will pay a $5,000 accidental death benefit. When Injury results in any one of the following covered losses within 365 days from the date of a covered accident, the Company will pay the benefit shown in the schedule below. Only one benefit, the largest, will be paid for more than one loss (including death) resulting from the same covered accident.

Loss of Life	$5,000
Loss of Both Hands or Both Feet or the Entire Sight of Both Eye	$20,000
Loss of One Hand and One Foot	$20,000
Loss of Either One Hand or One Foot and the Entire Sight of One Eye	$20,000
Loss of One Hand or One Foot or the Entire Sight of One Eye	$10,000
Loss of Thumb and Index Finger of the same Hand	$10,000
Loss of All Four Fingers of the Same Hand	$10,000

"Loss of a Hand or Foot" means complete Severance through or above the wrist or ankle joint. **"Loss of Sight"** means the total, permanent Loss of Sight of one eye. **"The Loss of Sight"** must be irrecoverable by natural, surgical or artificial means. **"Loss of a Thumb and Index Finger of the Same Hand"** or **"Loss of Four Fingers of the Same Hand"** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). **"Severance"** means complete separation and dismemberment of the part from the body.

OPTIONAL $100,000.00 ACCI-DENTAL BENEFIT

By adding $8.50 to your premium payment, dental benefits will be extended to provide payment for the Usual and Customary Expenses incurred within two years from the date of a covered accident for injury to sound and natural teeth, up to a maximum of $100,000 per covered accident, provided treatments and services begin within 90 days from the date of the covered injury. The following services are included in this benefit:

1. Replacement of caps, crowns, dentures, and orthodontic appliances (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the usual and customary charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Injury; if there is more than one way to treat a Dental issue, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. When a dentist certifies to the Claim Administrator that treatment will continue beyond the two year benefit period, a maximum of $1,500 will be paid. Treatment must be completed within two years of the expiration of the initial treatment period. This benefit is in effect 24 hours a day, even when purchased with School Time Accident Coverage.

ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 ACCIDENT MEDICAL EXPENSE BENEFITS

The company will pay the Usual and Customary Expenses incurred for a covered Injury, if the first treatment is received within 90 days after the Injury. The Schedule of Benefits is stated below. Benefits are payable up to a maximum of 52 weeks after the date of the covered Injury.

MAXIMUM BENEFITS
Hospital Services:
Daily Room & Board (Semi-private) . . . . . Up to $500/day
Intensive Care Room & Board . . . . . .Usual & Customary
(Not to exceed $1,000 per day for 7 days)

Miscellaneous Services:
During Hospital Confinement or when
surgery is performed . . . . Usual & Customary
(to a max. of $5,000)
Emergency Room out-patient: when
Hospital Confinement is not required . . $300.00 maximum

Doctor's Services:
Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of . . . . . $150 unit value
Anesthesia: (including administration)
and assistant surgeon: (% of
surgical allowance) 35%
Doctor Visits other than for Physiotherapy
or similar treatment when no surgery
benefit is paid . . . . . Usual & Customary
Consultants (when required by attending
Physician for confirmation or
determining a diagnosis, but not
for treatment) and
second opinion: . . . . . $150 maximum

Laboratory & X-Ray Services:
Other than Dental and including fee
for interpretation and/or reading of . . . . . X-Ray - $350.00
X-ray when not Hospital Confined . . . . . Lab - $350.00

Additional Services:
Physiotherapy or similar treatment:
In-Hospital . . . . . .Usual & Customary Maximum 30 Visits
Out of Hospital . . . . . $40 per visit Maximum 10 visits
Registered or Licensed Nurse (In or
out of the Hospital) . . . . . Usual & Customary
Ambulance to initial treatment facility . Usual & Customary
Orthopedic Appliances:
In-Hospital $950
Out of Hospital $500
Outpatient Drugs & Medication: Administered in Doctor's
office or by prescription: . . . . . Usual & Customary
Eyeglasses, Contact Lenses and Hearing Aids; replacement of broken eyeglasses and/or
frames, contact lenses, hearing aids, resulting
from a covered Injury . . . . . Usual & Customary

Dental Services:
For treatment, repair or replacement of
Injured natural teeth, includes initial braces when required for treatment of a covered Injury, as well as examinations, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis
resulting from trauma $400/tooth
Usual & Customary for braces

PRIMARY COVERAGE
Benefits are payable for covered medical expenses from the first dollar, no deductible, no coinsurance, paying in addition and without regard to payments by other insurance up to maximums stated herein. Benefits are payable for a maximum of 52 weeks, from the date of the injury.

EXCLUSIONS AND LIMITATIONS
Exclusions apply to the Accident Medical Expense Benefit (24-Hour Coverage and School Time Accident Coverage) and the Accidental Death and Dismemberment Benefit.

Limitation for Motor Vehicle Accidents
Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed $10,000.

Excluded Expenses
The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses; and
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

COMMON EXCLUSIONS:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. parachuting;
7. travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or indirectly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. injuries compensable under Workers' Compensation law or any similar law;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including traveling to and from games and practice, unless specifically provided for;
13. participation in any sports activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal School hours, including snowboarding skiing and ice hockey (does not apply if 24-Hour Coverage is selected);
14. benefits will not be paid for services or treatment rendered by any person who is:

    a. employed or retained by the Policyholder;

    b. living in the Insured Person's household;

    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or

    d. the Insured Person.

LIMITATIONS: Any Injury occurring, and expenses incurred there from, as a result of a covered accident which occurs while an Insured is engaged in an activity which is covered under the School's Compulsory Plan, will not be covered under a Voluntary Plan.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

Disclosure

THIS IS A BLANKET ACCIDENT ONLY POLICY.

The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.

US insurance coverage is underwritten by AXIS Insurance Company under group policy form series number [BACC-001-0909]. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES

TO FILE A CLAIM:

1. Claim form is attached to application.
2. Complete all fields in Parts I, II and III. Blanks or NA are not acceptable.
3. Be sure to sign and date the bottom.
4. Enclose itemized bills, paid receipts and/or other insurance explanation of benefits.
5. Send claim forms, itemized bills and receipts to:

90 Degree Benefits
PO Box 6540
Harrisburg, Pa 17112
phone: 1-800-427-9308 **fax:** (717) 652-8328 **email:** Student.Insurance@90degreebenefits.com

Proof of Loss is required within 90 days from the date of the Accident. You have ONE year from the time Proof of Loss would have been required to file a claim. Claims submitted past this period will not be considered for payment under the policy.

ENROLLMENT FORM CHECKLIST

DID YOU:

- ☐ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)
- ☐ Check the appropriate box(s) for the coverage you have selected.
- ☐ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

FOR QUESTIONS, INQUIRIES, AND INFORMATION CONTACT:

p: 1 (833) 636-3939
e: info@sportunderwriters.com

Sportunderwriters.com Inc
2047 Saranac Avenue, Suite 201
Lake Placid, NY 12946

DO NOT SEND CASH

ENROLLMENT FORM

Please Print

Pennsylvania 2024-2025

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY STATE ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

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 cr ime and subjects such person to criminal and civil penalties.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – ✓ CHECK YOUR SELECTION

COVERAGE PLANS	PREMIUMS
BEST BUY! 24-Hour	☐ $98.00
School Time	☐ $27.00
Dental Accident Insurance (with either of the above plans)	☐ $8.50

Make checks payable to SportInsurance.com

HOW TO ENROLL

1. Decide whether you want the School time, 24-Hour Accident Protection or Dental Plan.
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to the Administrator shown for the correct amount.
3. Mail envelope to Sportunderwriters.com Inc, 2047 Saranac Avenue, Suite 201, Lake Placid, NY 12946. Your cancelled check or money order stub will be your receipt and confirmation of payment. (Please write the student's name and school name on your check.)

1. **Please Fully Complete This Form**
2. **See Filing Instructions Attached**
3. **Mail To**

90 Degree Benefits
PO Box 6540, Harrisburg, PA 17112
Customer Service Hours: Mon-Fri 8a-4p EST
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: Student.Insurance@90degreebenefits.com

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity, or Sport:
Claimant's Name (Injured Person)	The Injured Person Was A: ☐ Participant ☐ Staff Member ☐ Other	Date and Time Of Accident:
Place Where Accident Occurred:	Type of Injury: (Indicate Part Of Body Injured and what side - e.g. broken left arm, etc.)	
Describe How Accident Occurred - Provide All Possible Details:		
Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Did Accident (Check Yes or No for Each of The Following):

A.	During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?	☐ YES	☐ No
B.	On Activity Premises:	☐ YES	☐ No
C.	While Traveling Directly and Uninterruptedly to Or Form the Activity?	☐ YES	☐ No
D.	During A Participating Organization Practice or Competition?	☐ YES	☐ No
E.	Did Injury Result in Death:	☐ YES	☐ No

Signature of Participating Organization Representative:	Name & Title of Participating Organization Representative:	Date:

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Best Contact Number (Included Area Code):	Social Security Number (Of Injured):	Gender (Of Injured): ☐ M ☐ F	Date of Birth (Of Injured):
Address (in which information should be mailed to):			

Do you/spouse/parent have medical/health care, or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.
2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT .
3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: 90 Degree Benefits for processing: paid receipts and/or balance due statements are not accepted.
4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

FRAUD WARNING

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.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).
2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.
3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.
4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)
5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.