Up to $1,000,000 Student Accident Medical Insurance Protection

Administered By:
LEFEBVRE INSURANCE, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

Local Service Agent:
Darien Insurance Center, Inc.
55 Frontier Road
Cos Cob, CT 06807
(203) 344-9545

2015-2016

Underwritten By:

AXIS Insurance Company

DO NOT SEND CASH

Enrollment Form

Please Print 2015-2016

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY ST ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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.

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 – 2015-2016 CHECK ✓ YOUR SELECTION

Coverage Plans	Premiums
24-Hour – Including Extended Dental	☐ $63.00
24 Hour Only	☐ $55.00
School Time – Including Extended Dental	☐ $23.00
School Time Only	☐ $15.00

Make checks payable to:

AXIS Insurance Company

How to Enroll

1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to AXIS Insurance Company for the correct amount.
3. Mail envelope to Lefebvre Insurance, LLC. – 850 Franklin Street – Wrentham, MA 02093. 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.)

MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO

MCA Administrators, Inc.

PO Box 6540
Harrisburg, PA 17112

CLAIM ASSISTANCE:

(800) 427-9308

UNDERWRITTEN BY: ACE AMERICAN INSURANCE COMPANY

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A. POLICY HOLDER

(1) Name of School District/College/Organization	Individual School/Team				(2) County	
(3) Address of School: (Street)	(City)	(State)	(Zip)	(4) Area Code - Telephone #	(5) Date of Injury MO DAY YR	
(6) Name of Injured Person	(7) Date of Birth MO DAY YR	(8) Social Security #	(9) Age	(10) Grade	(11) MALE ☐ FEMALE ☐	
(12) Injury occurred: Practice ☐ Game ☐ P.E. ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐					(13) Type of Sport:	
(14) Describe in detail HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.						
(15) What part of the body was injured: (Left or Right side if applicable)				(15a) Time of injury ____:____ a.m. ____:____ p.m.		
(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐						
(17) Name of Supervisor (if different from organization official)				(18) Was he/she a witness to accident? Yes ☐ No ☐		
(19) Signature of School or Organization Official			(20) Title of Official		(21) Date Signed MO DAY YR	

PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

(1) Name of Mother/Father or Guardian	(2) Social Security #	(3) Relationship to Insured ☐ Father ☐ Mother ☐ Guardian ☐ Self		
(4) Address (Number) Street (Lot or Apt. No.)	(5) City	(6) State	(7) Zip Code	
(8) Area Code – Home Telephone Number	(9) Father's work telephone ( ) _____ Mother's work telephone ( ) _____			
(10) Occupation of Father or Mother, Wife or Husband	(11) Place of Employment	(12) Address of Employer		
(13) Occupation of Self (if over age 18)	(14) Place of Employment	(15) Address of Employer		
(16) Do you have any other health and/or accident insurance plan (other than this plan?) Father: ☐ YES ☐ NO Mother: ☐ YES ☐ NO Husband: ☐ YES ☐ NO Wife: ☐ YES ☐ NO Self: ☐ YES ☐ NO				
(17) Is the injured person covered by other health and/or accident insurance plan? ☐ YES ☐ NO Effective Date MO DAY YR	(18) Name of other health and accident insurance company			
(19) Address of Insurance Company	(20) Policy Number	Phone #		

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, government agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administration to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the Policy identified above and that a copy of this Authorization shall be considered as valid as the original.
I agree that a photographic copy of this authorization shall be valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to intent to revoke.

Signature of Insured or Authorized Representative _____ Dated _____

Address _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

_____ Date

_____ Signature of Responsible Party or Student if 18 years old

Fraud 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.

SPORTS (K-12 SPECIAL RISK)

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 at the top of the claim form: **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, etc., and forward to the claim administration for processing.

FRAUD WARNING

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to 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 THIS 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.

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 Connecticut under form number BACC-001-0909. Complete details are found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information for your reference.

24 Hour Accident Coverage

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $55.00

SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees. Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $15.00

CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). You will receive a claim form which must be filed with the Company within 90 days after the accident. Covered Excess Expenses incurred within two years from the accident will be considered. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

Direct All Questions and Correspondence To:

LEFEBVRE INSURANCE, LLC
850 Franklin Street, Wrentham, MA 02093
(800)451-9668

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. DO NOT SEND CASH.

Disclosure: US insurance coverage is underwritten by AXIS insurance Company. 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. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. 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 for the under the Patient Protection and Affordable Care Act.

Optional $50,000 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means 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 & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Covered Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. If the Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $8.00

This coverage cannot be purchased without School Time or 24 Hour coverage.

Accidental Death & Dismemberment

When Injury shall result in any one of the following losses within 180 days from the date of accident, the company will pay for loss of:

Life $5,000
($15,000 for a death under the Sports Condition of Coverage)
Both hands or both feet or the
entire sight of both eyes $20,000
One Hand and One Foot $20,000
Either One Hand or One Foot and
the Entire Sight of One Eye $20,000
One Hand or One Foot or the entire
sight of one eye $10,000

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of thumb or index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics / activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

AMA-CT-SO-K-10-2015-10

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

The company will pay Usual and Customary Expenses incurred for a covered injury if treatment is received within 90 days after the injury. The Schedule of Benefits are stated below. Benefits are payable for 104 weeks from the date of the injury.

MAXIMUM BENEFITS

Hospital Services:

Daily Room & Board (Semi-private) ..... Up to $800/day

Intensive Care Room & Board ..... Usual & Customary not to exceed 7 days

Miscellaneous Services:

During Hospital Confinement or when surgery is performed $800/day

Emergency Room outpatient: when Hospital Confinement is not required ..... Usual & Customary

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 ..... $150.00 unit value

Anesthesia: (including administration) and assistant surgeon: % of surgical allowance 25%

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: ..... Usual & Customary

Laboratory & X-Ray Services:

Other than Dental and including fee for interpretation and/or reading of X-Ray

X-ray when not Hospital Confined X-Ray ..... Usual & Customary

Lab ..... Usual & Customary

MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for Interpretation and/or reading $800.00

Additional Services:

Physiotherapy or similar treatment:

In-Hospital ..... Usual & Customary

Out of Hospital $1,500.00

Chiropractic Services (in or out of hospital) $500.00

Registered Nurse (in or out of hospital) ..... Usual & Customary

Ambulance to initial treatment facility ..... Usual & Customary

Orthopedic Appliances:

In-hospital ..... Usual & Customary

Out of hospital $1,000.00

Out patient drugs & medication Administered by a Doctor ..... Usual & Customary

Eyeglasses, contact lenses and hearing aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered injury $650.00

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 examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma ..... $750 / tooth

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 104 weeks.

EXCLUSIONS AND LIMITATIONS

Exclusions: The policy does not cover any loss incurred as a result of;

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 the Benefit Limit shown in the *Schedule of Benefits.*

EXCLUDED EXPENSES:

For the purposes of this Accident Medical Benefit, 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;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
5. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).
6. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).

Common Exclusions: In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

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. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
4. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
5. parachuting;
6. Travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
7. 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 non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound, Accidental ingestion of contaminated food, or purposeful ingestion of controlled drugs;
8. A cardiovascular, event or stroke resulting, directly and independently of all other causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application);
9. voluntary use of any controlled substance as defined in title II of the Comprehensive Drug Abuse Prevention and control Act of 1970, as now or hereafter amended; unless as prescribed by his Physician for the Insured Person;
10. injuries compensable under Workers' Compensation law or any similar law, except where an employee is a corporate officer and where a sole proprietor or business partner is not covered by the provisions of chapter 568;
11. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including travelling to and from games and practice, unless specifically provided for in the Master Insurance Application;
12. 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;
13. 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.

To File A Claim:

1. Use attached claim form
2. Fill out all necessary information
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

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:

Lefebvre Insurance, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668