

# STUDENT ACCIDENT INSURANCE

Select the insurance plan that you need to offset the cost of medical care.....

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



**Enrollment Form Enclosed**

**APPROVED BY YOUR SCHOOL FOR GRADES PK-12**

***Make the Smart Choice Now!***



Marketed by  
**David Cates**  
The Brokerage Store  
4091 Dezavala Road, #3  
San Antonio, TX 78249  
210-366-4800 or Toll Free 800-366-4810

W-1745(TX)

# Premiums & Coverage

POLICY FORMS GH-2200 (TX)

One Time Annual Premiums

## School Time Coverage PK-12

(with NO UIL Activities/ Interscholastic Sports Coverage)

**\$20**

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. The Medical Benefits and Exclusions shown in this illustration apply to this coverage.

## Full Time Coverage PK-12

(with NO UIL Activities/ Interscholastic Sports Coverage)

**\$90**

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. The Medical Benefits and Exclusions shown in this illustration apply to this coverage.

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

**\$95**

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 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. The Medical Benefits and Exclusions shown in the illustration apply to the Coverage.

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

**\$165**

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 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. The Medical Benefits and Exclusions shown in this illustration apply to this Coverage.

## Varsity Football Coverage

**\$280**

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. The Medical Benefits and Exclusions shown in this illustration apply to this coverage.

## Extended Dental Coverage PK-12

**\$9**

Provides up to \$5,000 in benefits for any dental accident and covers the student 24 hours a day until school starts next year. Treatment must begin within 180 days from the date of injury. Benefits are limited to expenses actually incurred within one year from the date of accident. However, if within the one year period following the date of accident the insured's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the plan will pay the estimated cost of such deferred treatment, but not to exceed \$200 for each tooth. No benefits will be allowed for orthodontics or dental disease and 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.

### HOW TO ENROLL

1. Determine the Insurance Plan of coverage you want. 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](http://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 in the attached envelope.

### 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 expenses 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.

<b>A. IN-PATIENT BENEFITS</b> .....	<b>All Amounts Listed Below are Per Injury</b>
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) .....	First day up to \$1,000, thereafter up to \$500 per day; max \$5,000
4. Physician's Non-Surgical Visits (other than Physical Therapy) .. (not paid day of surgery).....	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.....	100% of U&C charges
<b>B. OUT-PATIENT SURGERY BENEFITS</b>	
1. Day Surgery (Facility Charge) Room supplies and all other expenses for out-patient surgery .....	U&C up to \$2,000
<b>C. OTHER OUT-PATIENT BENEFITS</b>	
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) ..	\$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 maximum
8. Shots and Injections (within 24 hours of an injury) .....	\$50 per injury
9. Prescription Drugs .....	\$50 per injury
10. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith).....	\$50 per visit; maximum 5 visits
11. Ambulance Service (Air or Ground).....	\$1,000 per injury
12. Eyeglass Replacement (if medical treatment is also received for a covered injury) .....	\$200 per injury
13. Durable Medical Equipment (Post-Surgical Only) .....	\$100 per injury
<b>D. OTHER PHYSICIAN SERVICES</b>	
1. Dental Treatment (in lieu of all other medical benefits, including X-rays of sound & natural teeth).....	\$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 per injury
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
<b>E. MOTOR VEHICLE INJURY</b> .....	up to \$1,000 max. as scheduled above
<b>F. OTHER BENEFITS</b> - Heat Stroke and Heat Exhaustion will be covered as any other accident.	
<b>G. ACCIDENTAL DEATH AND DISMEMBERMENT</b>	
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
Loss of an Eye .....	\$2,000
Double Dismemberment .....	\$10,000
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 7<sup>th</sup> grade or above, unless such premium is paid.

NOTICE: 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.

**NOTE: THIS IS A BLANKET TERM NON-RENEWABLE ACCIDENT POLICY**

**WHEN AND WHERE WILL MY STUDENT BE COVERED BY THIS INSURANCE?**

The choice is yours! This Insurance offering describes several enrollment options designed to fit your individual needs. Please review this entire brochure, especially the coverage descriptions, before making your selections.

**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 other insurance.

**WHAT KIND OF INSURANCE IS THIS?**

This is accidental bodily injury insurance; it covers accidental bodily injury occurring while the coverage is in force. Illnesses such as measles, sore throats, etc., are not covered.

**WHO SHOULD CONSIDER BUYING THIS INSURANCE?**

- 1. All families with no health insurance.
- 2. Families with policies having deductibles or co-pays.  
The larger the deductible or co-pay percentage, the more you can benefit. There is no deductible in our plan.

**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 plan will pay benefits in accordance with any applicable state law.  
These benefits are found in the master policy.**

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



This brochure is a summary of the master insurance policy issued to the educational institution. If there is a discrepancy between this brochure and the master policy, the master policy language will govern.

**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 DETACH AND PLACE THIS INFORMATION ALONG WITH YOUR PREMIUM WITHIN THE PROVIDED ENVELOPE.

***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
 ↑ STUDENT'S LAST NAME ↑ (one letter in each box) _____ STUDENT'S FIRST NAME _____ M.I. _____ Please Print Address _____ _____ (Street) _____ (City) _____ (State) _____ (Zip) Email Address _____ Name of School _____ Name of District _____ Student's Age _____ Grade _____ Phone _____ X _____ FORM W-1745(TX) (Signature of Parent or Guardian) (Date)		<b>School Time Coverage</b> (with NO UIL Activities / Interscholastic Sports Coverage)	<input type="checkbox"/> \$ 20
		<b>Full Time Coverage</b> (with NO UIL Activities / Interscholastic Sports Coverage)	<input type="checkbox"/> \$ 90
		<b>School Time Coverage</b> (with UIL Activities/Interscholastic Sports Coverage except Varsity Football)	<input type="checkbox"/> \$ 95
		<b>Full Time Coverage</b> (with UIL Activities/Interscholastic Sports Coverage except Varsity Football)	<input type="checkbox"/> \$165
		<b>Varsity Football Coverage</b>	<input type="checkbox"/> \$280
		<b>Extended Dental Coverage</b>	<input type="checkbox"/> \$ 9
<b>DO NOT SEND CASH</b>		<b>TOTAL PREMIUM</b>	<input style="width: 100px; height: 20px;" type="text"/>
Make Checks payable to: <b>STUDENT ASSURANCE SERVICES, INC.</b> *Please write student's name on the front of check. <b>NO REFUNDS</b> <b>NOTE: To apply for Student Accident Insurance, either complete this enrollment form or enroll on-line under K-12 School Look-up at: <a href="http://www.sas-mn.com">www.sas-mn.com</a></b>			

**STUDENT ACCIDENT INSURANCE CREDIT CARD PAYMENT**

INDICATE PREMIUM SELECTED AND COMPLETE THE REQUESTED ENROLLMENT INFORMATION FOUND ON THE REVERSE SIDE OF THIS FORM.

Please charge \$ \_\_\_\_\_ 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 ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

W-1745(TX)