n Accidents happen! When they happen to your child, someone must pay the bills.

n 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).

n These plans provide benefits to help meet the cost of medical and Hospital

n If you have other insurance, these plans can help offset the deductibles and

n If you have no other insurance, these plans will provide basic coverage.

n 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-A-Day*** ***Accident*** ***Coverage*** *(Including* *Summer* *Vacation)*

Helps protect your child for the entire school year and extends **throughout** **the** **summer** - right up to the day school re-opens. Your child’s coverage is good WORLDWIDE, 24-HOURS-A-DAY. This includes covered accidents:

At home At play While engaged in sports, except those On vacation 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

school sessions forltravel time required, but not more than one hour beforelor cipal’s office (duringrvacation timetcontact the administratorsrof the plan). Complete

tional time needed. Insurance Company within 90 days.

In addition, coverage is provided while participating in (or attending) covered Group Blanket Accident insurance products are issued on Form Series GP-2020 or GP-1200 by GuaranteeTrust Life Insurance Company, Glenview, IL.These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event

**Optional** **Football** **Only** **Accident** **Coverage** begins on the date of premium receipt of any conflict between the Policy and this brochure. For complete details of cover-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.** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

**K-12-OH-18-19-PDF** Underwritten and1 laimsilwaukee Ave., Glenview, IL 60025 • (800) 622-1993**OMPANY** **(GTL)**

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**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

Benefits are payable *up* *to* the dollar amounts shown

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 coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any oneAccident, including all related conditions and recurrent symp-toms of these injuries, are considered a single Injury.

|  |  |  |  |
| --- | --- | --- | --- |
| **COVERAGE** **and** **BENEFITS** **(continued)** | | | |
| **BENEFITS** **PER** **INJURY** | | **Low** **Option** | **High** **Option** |
| **Orthopedic** **Appliances** | Furnished by the Hospital | **$100** | **$200** |
| **Dental** **Treatment** | Treatment For Injury To Sound, Natural Teeth, per tooth  Up to a maximum of | **$200** **$600** | **$400** **$1,200** |
| **Accidental** **Death** **and** **Dismemberment** Only one of these benefits, the largest, will be payable in addition to the benefits shown | If Injury causes death or dismemberment within 365 days of the Accident, the plan pays as follows:  Loss of Life  Loss of One Hand or One Foot  Loss of the Entire Sight of Both Eyes Loss of Both Hands or Feet | **$2,000** **$1,000** **$1,000** **$10,000** | |

**EXCLUSIONS** **-** **The** **Policy** **does** **not** **provide** **benefits** **for:** 1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as nec-essary to treat an Injury; are determined to be 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 received while violating or attempting to vio-late 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 regu-larly scheduled commercial airline. 6) Injury covered by Workers' Compensation or the Occupational Disease Law. 7) Treatment of illness, disease or infections, except infec-tions which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance. 8) Hernia of any type. 9) Injury sustained fighting or brawling, except in self-defense. 10) Suicide or attempted suicide. 11) Loss resulting from the use of any drug or agent classified as narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor. 12) Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four- wheeled recreational motor/engine driven vehicle or snowmobile or all terrain vehicle (ATV). 13) Injury sus-tained 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. 14) Cosmetic or plastic surgery, except for reconstruc-tive surgery on an injured part of the body. 15) Treatment in any Veteran’s Administration or federal Hospital, except if there is a legal obligation to pay. 16) 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. 17) Dental treatment, except as specif-ically stated. 18) Services of an assistant surgeon or Doctor when surgery is per-formed. 19) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore. 20) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

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**2018-19** **SCHOOL** **YEAR** **ENROLLMENT** **FORM**

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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.

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