GTL GUARANTEE TRUST LIFE 2024-2025 Student Accident Insurance Plans

- Accidents happen! When they happen to your child, someone must pay the bills.
- 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).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- 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	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL), its representatives or school officials (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

Optional Football Only Accident Coverage begins on the date of premium receipt 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.

To file a claim: Report accidents to the school. Forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). Complete proof of loss and accumulated bills must be received by Guarantee Trust Life Insurance Company within 90 days.

24-Hour-A-Day Accident Coverage

24-Hour-A-Day Protection for each Covered Accident

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

✎ At home ✎ At play ✎ At school ✎ On vacation ✎ Scouting, camping etc. ✎ During covered travel

✎ While engaged in sports, except those 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 coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

TERMINATION OF POLICY/CERTIFICATE OF COVERAGE: The Policy is issued for the agreed upon term of coverage and is non-renewable. Coverage will terminate at the earlier of: (1) the date the Policy terminates; or (2) the date the Insured ceases to be a member of the Policyholder's sports teams; or (3) the last day of regularly scheduled sports activity; or (4) the date the Insured ceases to be an Eligible Person; or (5) the end of the period for which any applicable premium has been paid. We have the right to terminate the coverage of any Insured who submits a fraudulent claim under the Policy.

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

Coverage and Benefits

BENEFITS ARE PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		Low Option	High Option
HOSPITAL ROOM AND BOARD AND GENERAL NURSING CARE	Per day	**$150**	**$300**
HOSPITAL MISCELLANEOUS EXPENSE		**$1,000**	**$2,000**
HOSPITAL EMERGENCY CARE		**$150**	**$300**
DOCTOR'S FEES FOR SURGERY	Limited to a maximum of	**$1,500**	**$3,000**
ANESTHESIA SERVICES		**100% of Reasonable & Customary**	
AMBULANCE EXPENSE		**$100**	**$200**
DOCTORS' VISITS **Non-surgical** Including Physical Therapy	Per visit	**$25**	**$50**
	Physical Therapy, per visit	**$25**	**$50**
	Maximum number of visits per Injury	**3**	**3**

BENEFITS PER INJURY		Low Option	High Option
IMAGING PROCEDURES	Including X-rays and interpretation	**$100**	**$200**
MRI/CAT Scan		**$125**	**$250**
ORTHOPEDIC APPLIANCES	Furnished by the Hospital	**$100**	**$200**
DENTAL TREATMENT	For Injury to Sound, Natural Teeth, per tooth	**$200**	**$400**
	Up to a maximum of	**$600**	**$1,200**
ACCIDENTAL DEATH AND DISMEMBERMENT Only one of these benefits, the largest, will be payable in addition to other benefits shown	Caused by an Injury and occurring within 365 days of the covered Accident		
	ACCIDENTAL DEATH	**$2,000**	
	DISMEMBERMENT		
	Loss of One Hand or One foot	**$1,000**	
	Loss of the Entire Sight of Both Eyes	**$1,000**	
	Loss of Both Hands or Feet	**$10,000**	

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 one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

EXCLUSIONS - THE POLICY DOES NOT COVER: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are 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 sustained while violating or attempting to violate 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 regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) Treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (12) Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; (13) Injury sustained while operating, riding in or upon, mounting or alighting from, any two, three or four- wheeled recreational motor/engine driven vehicle, snowmobile or all-terrain vehicle (ATV); (14) Injury sustained 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; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) 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; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

Blanket Accident insurance is issued under Policy Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. The policy has exclusions, limitations, reductions of benefits, and conditions of eligibility and termination. Subject to state availability and variability. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage, please contact the agent administering the program.

Administered by: **STUDENT PROTECTIVE AGENCY,** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544
Underwritten and claims paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL),** 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

2024-2025 School Year Enrollment Form

GTL GUARANTEE TRUST LIFE

PLEASE PRINT CLEARLY

One Time Annual Payment		
OPTIONS	**Low Option**	**High Option**
24-Hour-A-Day Plan		
Students Grades K-6	❑ $79	❑ $158
Students Grades 7-12	❑ $91	❑ $182
School-Time Plan		
Students Grades K-6	❑ $23	❑ $46
Students Grades 7-12	❑ $37	❑ $74
Optional Football Coverage (Grades 10-12, including grade 9 if playing with 10-12) 2024 Season Only Per Player	❑ $129	❑ $258
TOTAL $_____ (Please do not send cash)		
Make check payable to your local agency		
No Refunds are available		

Student's Name _____
First Name Middle Initial Last Name

Date of Birth _____ **Male** ❑ **Female** ❑
Month Day Year

School District _____ **School** _____

Grade _____ **Student's Address** _____

City _____ **State** _____ **Zip** _____

Telephone # _____ **Date of Enrollment** _____

Parent or Guardian's Email Address _____

Name of Parent or Guardian (please print) _____

_____
Signature of Parent or Guardian

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.

GTL GUARANTEE TRUST LIFE — PLANES DE SEGUROS DE ACCIDENTES PARA ESTUDIANTES 2024-25

- ¡Los accidentes son comunes! Cuando le suceden a su hijo, alguien debe pagar esos costos.
- Aquí le presentamos planes de seguros contra accidentes para cubrir a su hijo las 24 horas del día (Plan de 24 horas) o en la escuela (Plan de Tiempo Escolar).
- Estos planes ofrecen beneficios para ayudar a cubrir el costo de los gastos médicos y hospitalarios.
- Si tiene otro Seguro, estos planes pueden ayudar a compensar los deducibles y coaseguro de dichos planes.
- Si no tiene otro seguro, estos planes proporcionarán cobertura básica.
- Cualquier beneficio pagable por esta póliza como resultado de un servicio médico, quirúrgico, dental, hospitalario o de enfermería será pagado directamente al hospital o a la persona que proporcione dichos servicios, a menos que se proporcione prueba del pago completo. .

24-Horas	Tiempo Escolar	DETALLES IMPORTANTES SOBRE LA PROTECCIÓN
✓	✓	Entra en vigor en la fecha en que Guarantee Trust Life Insurance Company (GTL) sus representantes o funcionarios escolares reciben el pago de la prima (pero no antes del primer día de clases). Los estudiantes que participen en prácticas preescolares o practiquen deportes interescolares autorizados por la Asociación Atlética de Escuelas Secundarias de Ohio estarán cubiertos a partir de la misma fecha del pago de la prima, pero solo mientras participen en sesiones de práctica o juego. Otros aspectos de la cobertura no entrarán en vigor hasta el primer día de clases regulares.
✓	✓	Proporciona cobertura durante las horas en las cuales la escuela está en actividades regulares.
✓		Proporciona cobertura las 24 horas del día.
✓	✓	Ofrece cobertura durante el tiempo necesario para el viaje entre la casa del asegurado y el comienzo o final de clases regulares.
✓	✓	Brinda cobertura mientras participa (o asiste) a actividades organizadas, patrocinadas y supervisadas por la escuela. También se proporciona cobertura para viajar directamente hacia y desde tales actividades en un Vehículo Designado provisto por la escuela.
	✓	La cobertura expira al terminar el ciclo escolar regular. (La cobertura se extenderá mientras se asista a clases académicas para obtener créditos en el verano, cuando las actividades escolares son patrocinadas y supervisadas exclusiva y únicamente por la escuela, no se proporcionará cobertura para el transporte de y hacia las clases.)
✓		La cobertura continúa sin interrupción todo el verano, hasta que la escuela inicie el siguiente ciclo escolar.

La cobertura opcional de fútbol comienza en la fecha en que GTL, sus representantes o los oficiales de la escuela reciban la prima, pero no antes de la primera fecha oficial de entrenamiento, y continúa hasta la fecha del último partido oficial de la temporada actual, incluyendo las eliminatorias.
La prima de fútbol cubre solo fútbol.

Para presentar un reclamo: reporte los accidentes a la escuela. Los formularios se proporcionarán a través de la oficina del director (durante las vacaciones, comuníquese con los administradores del plan). La prueba completa de la pérdida y las facturas acumuladas debe ser recibida por Guarantee Trust Life Insurance Company dentro de los 90 días posteriores al accidente.

COBERTURA DE ACCIDENTES LAS 24 HORAS DEL DÍA

¡Protección las 24 horas para cada accidente cubierto!

Proteja a su hijo durante todo el año escolar y se extiende durante el verano - hasta que la escuela inicie nuevamente.

Su hijo estará cubierto EN TODO EL MUNDO, LAS 24 HORAS DEL DÍA.

Esto incluye accidentes cubiertos: ✎ En el hogar ✎ Al jugar ✎ En la escuela

✎ Durante las vacaciones ✎ Al acampar, explorar, etc. ✎ Durante viajes cubiertos

✎ Mientras participe en deportes, excepto aquellos que estén excluidos específicamente o para los cuales se requiere cobertura opcional*

*Vea las OPCIONES para descubrir cualquier cobertura opcional para deportes.

COBERTURA DE ACCIDENTES DURANTE EL TIEMPO ESCOLAR

Ayuda a proteger a su hijo mientras asiste a clases regulares. Incluye cobertura para los viajes directos hacia y desde su residencia para asistir a clases regulares, durante el tiempo de viaje requerido, pero durante no más de una hora antes o después de las clases regulares. El tiempo de viaje en el autobús escolar se extiende por cualquier tiempo adicional necesario. Además, se ofrece cobertura mientras se participa en (o se asiste) a actividades cubiertas organizadas, patrocinadas y supervisadas exclusivamente por la escuela y los empleados de la escuela, incluido el viaje directo hacia y desde la actividad en un Vehículo designado proporcionado por la escuela y supervisado únicamente por los empleados de la escuela. Es posible que se requiera cobertura opcional para los deportes interescolares. Consulte OPCIONES para conocer la cobertura deportiva opcional disponible, si corresponde.

RESCISIÓN DE LA PÓLIZA/CERTIFICADO DE COBERTURA: La Póliza se emite por el plazo de cobertura acordado y no es renovable. La cobertura terminará en la fecha que ocurra primero entre: (1) la fecha de terminación de la póliza; o (2) la fecha en que el asegurado deja de ser miembro de los equipos deportivos del titular del seguro; o (3) el último día de actividad deportiva programada regularmente; o (4) la fecha en que el asegurado deja de ser una persona elegible; o (5) el final del período por el cual se ha pagado cualquier prima aplicable. Tenemos derecho a cancelar la cobertura de cualquier asegurado que presente un reclamo fraudulento bajo la póliza.

¿Qué cubren? *Hasta un* máximo de $25,000 de acuerdo a la descripción de Cobertura y Beneficios:

- Accidentes que ocurran durante la vigencia de la cobertura.
- Pérdida debido a lesiones accidentales que resulten directa e independientemente de todas las otras causas.
- Gastos médicos cubiertos que comienzan dentro de los 30 días posteriores al accidente e incurridos dentro de las 52 semanas posteriores al accidente.

COBERTURA Y BENEFICIOS

Los beneficios se pagan *hasta el* monto en dólares especificado a continuación

BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta
ALOJAMIENTO Y COMIDA EN HOSPITAL Y CUIDADOS GENERALES DE ENFERMERÍA	Por día	$150	$300
GASTOS VARIOS DE HOSPITAL		$1,000	$2,000
ATENCIÓN DE EMERGENCIA HOSPITALARIA		$150	$300
HONORARIOS MÉDICOS POR CIRUGÍA	Limitado a un máximo de	$1,500	$3,000
SERVICIOS DE ANESTESIA		100% de lo razonable y usual	
GASTOS DE AMBULANCIA		$100	$200
CONSULTAS MÉDICAS No quirúrgicas Incluye terapia física	Por consulta	$25	$50
	Terapia física por consulta	$25	$50
	Número máximo de consultas por lesión	3	3

BENEFICIOS POR LESIÓN		Opción Baja	Opción Alta
PROCEDIMIENTOS DE IMAGENOLOGÍA	Incluye radiografías e interpretación	$100	$200
EXPLORACIÓN POR MRI/TAC		$125	$250
APARATOS ORTOPÉDICOS	Provistos por el hospital	$100	$200
TRATAMIENTO DENTAL	Para Lesiones en dientes naturales sanos, por diente	$200	$400
	Hasta un máximo de	$600	$1,200
MUERTE ACCIDENTAL Y DESMEMBRAMIENTO Solo uno de estos beneficios, el más grande, será pagadero además de otros beneficios que se mencionan	Causado por una lesión y ocurrido dentro de los 365 días posteriores al accidente cubierto		
	MUERTE ACCIDENTAL	$2,000	
	DESMEMBRAMIENTO		
	Pérdida de una mano o un pie	$1,000	
	Pérdida de la vista completa de ambos ojos	$1,000	
	Pérdida de ambas manos o pies	$10,000	

Una Lesión es toda Lesión corporal originada en un Accidente que resulte directa e independientemente de una enfermedad, dolencia corporal o cualquier otra causa; que única, directa e independientemente de todas las demás causas, resulte en gastos médicos; que ocurra después de la fecha de entrada en vigor de la cobertura del Asegurado por la Póliza; y que ocurra mientras la Póliza esté en vigor. Todas las lesiones sufridas en cualquier Accidente, entre ellas todas las condiciones relacionadas y los síntomas recurrentes de estas lesiones, son consideradas una sola Lesión.

EXCLUSIONS - LA PÓLIZA NO CUBRE: (1) tratamientos, servicios o suministros que no sean Médicamente necesarios; no recetados por un Médico como necesarios para tratar una Lesión; de naturaleza experimental/de investigación; recibidos sin cargo ni obligación legal de pago; recibidos de personas empleadas o contratados por el Titular de la Póliza o cualquier Miembro de la Familia, salvo que se especifique lo contrario; o no catalogados específicamente como Cargos Cubiertos en la Póliza; (2) lesiones autoinfligidas intencionalmente; (3) lesiones sufridas al violar o intentar violar cualquier ley debidamente promulgada; (4) lesiones por actos de guerra, declarada o no; (5) lesiones recibidas durante un viaje o vuelo, excepto en el caso en el que se viaje como pasajero que paga una tarifa en una aerolínea comercial regular; (6) lesiones cubiertas por la Ley de Compensación al Trabajador o la Ley de Enfermedades Ocupacionales; (7) tratamientos de enfermedades, dolencias o infecciones, excepto infecciones que resulten de una Lesión accidental o infecciones que resulten de la ingestión accidental, involuntaria o no intencional de una sustancia contaminada; (8) hernias, de cualquier tipo; (9) lesiones sufridas en peleas o reyertas, excepto en defensa propia; (10) suicidio o intento de suicidio; (11) cualquier sanción impuesta por otro seguro o plan válido y cobrable por no seguir los procedimientos del plan; (12) pérdida resultante del uso de cualquier droga o agente clasificado como narcótico, psicolítico, psicodélico, alucinógeno o que tenga una clasificación o efecto similar, a menos que sea recetado por un Médico; (13) lesiones sufrida al operar, viajar en, subirse o bajarse de cualquier vehículo recreativo de dos, tres o cuatro ruedas con motor, motonieve o vehículo todo terreno (ATV, por sus siglas en inglés); (14) lesiones sufridas mientras se participa en o practicaba fútbol americano interescolar de escuela preparatoria, incluido el grado 9 si jugaba en el grado 10 o superior, incluido el viaje, a menos que se haya comprado una cobertura opcional; (15) cirugías cosméticas o plásticas, excepto cirugías reconstructivas en una parte lesionada del cuerpo; (16) tratamientos en cualquier Administración de Veteranos u Hospital federal, excepto si existe una obligación legal de pago; (17) pérdida resultante de estar legalmente intoxicado o bajo la influencia del alcohol según lo definido por las leyes del estado en el que ocurre la Lesión; (18) tratamientos odontológicos, salvo que se indique específicamente; (19) servicios de un cirujano asistente o Doctor cuando se realiza una cirugía; (20) anteojos, lentes de contacto, exámenes oculares de rutina o recetas para los mismos; (21) medicamentos recetados, muletas, aparatos ortopédicos, miembros artificiales, etc., salvo que se indique específicamente.

El seguro Blanket contra Accidentes se emite según la serie de formularios de póliza GP-2030, GP-2020 o GP-1200 por Guarantee Trust Life Insurance Company, Glenview, IL. La póliza tiene exclusiones, limitaciones, reducciones de beneficios y condiciones de elegibilidad y terminación. Sujeto a disponibilidad y variabilidad estatal. La Póliza prevalecerá en caso de conflicto entre la Póliza y este folleto. Para obtener detalles completos de la cobertura, comuníquese con el agente que administra el programa.

Administrado por: **STUDENT PROTECTIVE AGENCY,** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

Pagadas por: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL),** 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

FORMULARIO DE INSCRIPCIÓN PARA EL AÑO ESCOLAR 2024-25

SOLO UN PAGO POR AÑO		
OPCIONES	Opción Baja	Opción Alta
PLAN DE 24 HORAS AL DÍA		
ESTUDIANTES DE GRADOS K-6	❑ $79	❑ $158
ESTUDIANTES DE GRADOS 7-12	❑ $91	❑ $182
PLAN DE TIEMPO ESCOLAR		
ESTUDIANTES DE GRADOS K-6	❑ $23	❑ $46
ESTUDIANTES DE GRADOS 7-12	❑ $37	❑ $74
COBERTURA OPCIONAL DE FÚTBOL (GRADOS 10-12, INCLUYENDO GRADO 9 SI SE JUEGA EN 10-12) TEMPORADA 2024 SOLO POR JUGADOR	❑ $129	❑ $258
TOTAL $_____ Por favor no envíe efectivo		

EXTIENDA EL CHEQUE A FAVOR DE SU AGENCIA LOCAL

NO HAY REEMBOLSOS DISPONIBLES

GTL GUARANTEE TRUST LIFE

POR FAVOR ESCRIBIR CLARAMENTE:

Nombre del Estudiante _____
Primer Nombre Inicial 2o. Nombre Apellido

Fecha de Nacimiento _____ **Masculino** ❑ **Femenino** ❑
Mes Día Año

Distrito Escolar _____ **Escuela** _____

Grado _____ **Dirección del estudiante** _____

Ciudad _____ **Estado** _____ **Código postal** _____

Teléfono # _____ **Fecha de inscripción** _____

Correo electronico del Padre o Tutor _____

_____
Nombre Del Padre O Tutor (En Letra De Molde)

_____
Firma del Padre o Tutor

POR FAVOR RECUERDE:

COMPLETAR EL FORMULARIO DE INSCRIPCIÓN Y MARCAR EL PLAN Y LAS OPCIONES QUE DESEA.

EMITIR SU CHEQUE O GIRO POSTAL (POR FAVOR NO ENVÍE EFECTIVO) POR EL TOTAL A PAGAR DE ACUERDO A LO INDICADO.

Envíe su formulario de inscripción con su cheque o el giro postal a:

STUDENT PROTECTIVE AGENCY
300 Coshocton Avenue
Mount Vernon, OH 43050

TENGA EN CUENTA: SU CHEQUE CANCELADO ES SU RECIBO. SI EL CHEQUE CANCELADO NO SE RECIBE DENTRO DE LOS 60 DÍAS, COMUNÍQUESE CON EL ADMINISTRADOR DE SU PLAN.

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT CLAIM FORM

- Parts 1 and 3 of the claim form must be completed and signed by a parent or guardian (or the student, if an adult). Part 2 of the claim form must be completed and signed by a School official.
  Also, the *HIPAA Authorization To Permit Use and Disclosure of Health Information* must be completed and signed.

- Your School Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Policy for the "Initial Treatment Period."

- PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED **WITHIN 90 DAYS OF THE ACCIDENT**. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED **WITHIN 90 DAYS OF TREATMENT**.

- Please attach itemized bills to the claim form. A balance due bill from your provider is not sufficient.
  An itemized bill is a statement that indicates:
  1) **The date(s) of treatment,**
  2) **The type(s) of service,**
  3) **The diagnosis,**
  4) **The medical provider's name and address,**
  5) **And the individual charge for each expense**.

- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.

- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of
- Benefits") statements (if applicable) to: Guarantee Trust Life Insurance Company
  PO Box 1144
  Glenview, IL 60025

- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please notate this on the bills or in Part 1 of the claim form.

- Only one completed claim form per accident is required to be sent to us. Additional related bills or follow-up treatment to be sent to us should indicate the student's name, school name and/or policy number and date of accident.

- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please note that your claim will result in a processing delay as the result of not providing us with the following: the completed claim form, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at 800-338-7452.

GTL | GUARANTEE TRUST LIFE

Mail claims to:
PO Box 1144, Glenview, IL 60025
Or fax to: 847-699-1048
Or e-mail to: Claims@gtlic.com
For Customer Service, please call: 800-338-7452

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

SPECIAL RISK ACCIDENT CLAIM FORM

PART 1 - ASSIGNMENT OF BENEFITS:

Dr: _____	Hosp: _____	Other: _____
Addr: _____	Addr: _____	Addr: _____
_____	_____	_____
_____	_____	_____
City, State Zip	City, State Zip	City, State Zip

I hereby authorize Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____
Claimant - if an ADULT

PART 2 - SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT: (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. Claimant's FULL NAME _____ Alternate Name _____ Date of Birth _____ Grade ___
2. Claimant's Address: Street or RFD _____ City _____ State ___ Zip _____
3. Date of Accident _____ 20___ Hour _____ ☐ AM ☐ PM
4. Description of Accident: **(A)** How and where did it occur? _____
_____ (if more space needed, attach separate sheet)
(B) Nature of Injury _____
5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ ☐ Intramural ☐ Interscholastic ☐ Other
6. **(A)** On date of accident what time did school start for this student? _____ ☐ AM ☐ PM
(B) What time was student dismissed from school? _____ ☐ AM ☐ PM
7. Has a previous claim been filed for this accident? ☐ Yes ☐ No
8. **(A)** Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? ☐ Yes ☐ No
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: ☐ Elementary ☐ Jr. High ☐ High ☐ Other

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PART 3 - PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY? ☐ Yes ☐ No

IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:

Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: _____ _____

Employer's Name: _____

Employer's Address: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: _____ **SIGNATURE** _____

Guarantee Trust Life Insurance Company, PO Box 1144, Glenview, Illinois 60025
800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy / Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to GTL, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent GTL has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that GTL may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(Print Please) Name of Patient	Date of Birth
Signature of Patient	Date
(Please Print) Name of Authorized Representative, or Next of Kin	
Relationship of Authorized Representative or Next of Kin to Patient	
Signature of Authorized Representative or Next of Kin	Date

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

General Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia - 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.

Florida - Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky - A person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FILES AND CRIMINAL PENALTIES.

Ohio and Oregon - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Tennessee, Virginia and Washington State - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Texas - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.