

STUDENT ACCIDENT INSURANCE



Parents and Guardians

- Do you have adequate insurance coverage for your Child in the event of an unforeseen accident?
- Do you have current coverage with high deductibles or co-payments? This student accident coverage may help fill those costly gaps.
- You can protect your child with one of our Accident plans designed to meet your needs

Please keep this brochure as an outline of coverage for future reference.



Bob McCloskey Insurance
800.445.3126



Insurance Underwritten by:
Berkley Life and Health Insurance Company
a Berkley Company, A+ rated by A.M. Best (Superior)

As diverse as a typical school day,
our student accident plans can
accommodate almost any need.



SUMMARY OF BENEFITS AND LIMITATIONS

(What the plan pays)

The Policy provides benefits for a loss due to a covered injury as defined in the Policy up to a maximum benefit as described below for each injury. The coverage would be for those medical/dental expenses incurred within 104 weeks from the date of the original Accident. Treatment must begin within 60 days from the date of the Accident by a legally licensed medical or dental practitioner (not a member of the Insured's immediate family).

An Accident is defined in the policy as a sudden, unexpected event that results in Injury to the Covered Person.

ACCIDENTAL MEDICAL AND DENTAL EXPENSE BENEFITS

Maximum Accident Medical Policy Limit	\$500,000
Motor Vehicle Accidents	\$10,000 maximum
Hospital room and board expenses	\$500 per day
Daily Intensive Care Unit/ Cardiac Care Unit Expenses	\$1,000 per day up to 5 days
Ancillary Hospital expenses	\$500 maximum
Physician non-surgical (inpatient)	Usual & Customary Charges
Physician surgical expenses	Usual & Customary
Assistant Surgeon expenses	25% of Physician surgical
Anesthesiologist expenses	25% of Physician surgical benefit
Outpatient surgery expenses	\$500 maximum
Physician non-surgical (outpatient)	Usual & Customary Charges
Physician Consultant Expense (outpatient)	Usual & Customary Charges
Physiotherapy (outpatient)	Usual & Customary up to a maximum of \$2,000
Ambulance expenses	Usual & Customary Charges
X-ray expenses (outpatient)	Usual & Customary Charges
Outpatient laboratory test expenses	Usual & Customary Charges
Diagnostic imaging expenses	\$500
Medical Emergency Care	\$500
Prescription drug expenses	Usual & Customary Charges
Outpatient registered nurse services	Usual & Customary Charges
Rehabilitative braces or appliances	\$2,000 maximum
Dental expenses	\$500 per tooth maximum
Deferred Dental Treatment (when certified by a dentist)	\$1,000
Eyeglasses, contact lenses and hearing aids	\$500 maximum

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, within 365 days from the date of a Covered Accident, Injury to the Covered Person results in any of the Covered Losses shown below, We will pay the benefit in the amount set opposite such Loss, as shown on the Schedule of Benefits. If multiple Losses occur, only one Benefit, the largest, will be paid for all Losses due to the same Covered Accident.

Loss of Life	\$10,000
Loss of Two or More Members	\$50,000
Loss of One Member	\$25,000
Loss of Thumb & Index Finger of the Same Hand	\$2,500
Loss of Four Fingers of the Same Hand	\$2,500

POLICY EXCLUSIONS

This Policy does not cover any Loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the Loss is an accidental bodily injury, unless otherwise covered under the Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
6. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
7. Participation in any motorized race or speed contest.
8. Aggravation or re-injury of a prior injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
9. Any injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
10. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
11. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
12. Treatment of a hernia whether or not caused by a Covered Accident.
13. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: Except as a fare paying passenger on a regularly scheduled commercial airline.

IMPORTANT NOTE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

HOW DO YOU FILE A CLAIM?

1. Obtain a claim form from your school office or Bob McCloskey Insurance. (800-445-3126), and answer all questions in detail on the front of the claim form.
2. The claim form should identify the student's name, school name or district, and the date of accident.
3. Make sure the claim form is signed.
4. Attach all itemized bills to the completed claim form and mail to Bob McCloskey Insurance at the address provided on the claim form.
5. Bills that cannot be attached to the initial form must be submitted within **90 days of the date of service.**



Claims Administrator:

Bob McCloskey Insurance
P.O. Box 511
Matawan, NJ 07747
Phone: 800-445-3126

DEFINITIONS

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

INJURY means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICALLY NECESSARY means a treatment, service or supply that is:

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

ADDITIONAL FACTS ABOUT THE COVERAGE

1. This is a **Limited Benefit Policy**
2. The Blanket Accident Policy on file with the school is a non-renewable one year term policy.
3. **EFFECTIVE DATE OF COVERAGE:** Insurance is effective on the latest of the following dates:
 - the Policy Effective Date;
 - the date the Covered Person is first eligible;
 - the date We receive the completed enrollment form; or
 - the date the required premium is paid.
4. **EVIDENCE OF COVERAGE:** A copy of your cancelled check or money order receipt and a copy of this brochure is your evidence of coverage under the School Sponsored Accident Policy.
5. **STUDENT TRANSFER:** Coverage under the Policy continues in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.
6. **CANCELLATION:** Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
7. **LATE ENROLLMENT:** There is no premium reduction for any individual who enrolls late in the year



Cut and Keep for your records:

2011-2012 STUDENT INSURANCE ID CARD

Student's Name: _____

If premium has been paid, the student whose name appears above has been insured under an Accident Only program covering students of:

School Name: _____

Coverage: Around the Clock Coverage Dental Coverage

Paid by Check # _____ Amount Paid: \$ _____ Date: _____

Claims Questions: (800) 445-3126

YOU CAN CHOOSE THE PLAN THAT IS RIGHT FOR YOU!

Premiums & Coverage Available

Around the Clock Coverage (Accident Only)

\$ 65.00

Around-the-clock/anywhere in the world 24 hours a day; until one year after the date the Policy coverage begins. Coverage ends when school reopens the following school year. Covers eligible injuries resulting from covered accidents:

- Before, during and after school
- Weekends, vacation and all summer including summer school
- School sponsored and supervised extracurricular activities excluding interscholastic sports

Dental Coverage (Accident Only)

\$ 11.00

- Voluntary supplemental Dental coverage in effect 24 hours a day extended to students with Around the Clock or At School Coverage.
- Benefits not to exceed a maximum of \$50,000 when injury to sound natural teeth requires treatment within 60 days of a covered accident.
- Only eligible expenses incurred by the Covered Person within the Benefit Period from the date of the accident are covered.
- If a dentist certifies that treatment must be deferred, deferred benefits will be paid to a maximum of \$1,000.

IMPORTANT: RETAIN THIS SUMMARY FOR YOUR PERSONAL RECORDS as a DESCRIPTION OF COVERAGE.

Keep a copy of your cancelled check or
money order receipt as evidence of payment.

IMPORTANT: This brochure is only a summary of your benefits under the accident plan of insurance sponsored by your school and is only a partial description of the entire insurance plan. It is not a contract of insurance. This brochure and its contents are intended to provide an overview of the insurance coverage provided under the Policy. Your coverage is governed by a policy of student accident insurance underwritten by Berkley Life and Health Insurance Company under Blanket Policy AH51051 provided to your school. If there is a discrepancy between this brochure and the master Blanket policy, the master policy language will govern.

A copy of the full Policy of insurance describing the benefits which are payable in accordance with the terms, conditions, and exclusions has been provided to your school and is available for viewing at your schools office. Please remember that only the complete Blanket Accident Insurance Policy can provide the actual terms of coverage and will govern and control the payment of benefits. Benefits described in the Policy will be paid in accordance with any applicable state law.

ENROLLMENT FORM FOR STUDENT ACCIDENT INSURANCE

2011-2012 SCHOOL YEAR

COMPLETE THE ENROLLMENT FORM

- Complete the enrollment form and detach the envelope.
- Make Check or Money Order payable to Bob McCloskey Insurance (Do NOT send cash).
- Be sure to include your child's name on your check
- Insert Check or Money Order in the envelope.
- Fold, seal and return envelope to Bob McCloskey Insurance
- Remember to keep your cancelled check or money order receipt as proof and confirmation of payment
- RETAIN this summary document for your personal records as a description of coverage.
- Cut out and Keep the Student Insurance ID CARD

School System: _____

School Name: _____

Student Last Name: _____

Student First Name: _____

Student Date of Birth (mo/day/year) / / SEX: M F

Student Home Phone: () _____

Student Address: _____

(STREET)

(CITY) _____ (STATE) _____ (ZIP) _____

PLAN SELECTION

(check one)

Around the Clock Coverage

Dental Coverage

Annual Premium

\$ 65.00 _____

\$ 11.00 _____

Make Check or Money Order payable to:
Bob McCloskey Insurance

Amount Enclosed: _____

Check or Money Order Number: _____

Signature of Parent or Guardian

Date

Return To: Bob McCloskey Insurance