

# ILLINOIS 2018/2019

## Benefits and Premiums

**All Maximum amounts are per Injury except as specifically stated.**

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.

COVERAGE AND BENEFITS	STANDARD PLAN	DELUXE PLAN
Maximum Benefit Amount Per Injury	\$25,000.00	\$25,000.00
Deductible	\$0.00	\$0.00
Hospital Room and Board and general nursing care limited to a maximum of	\$200.00/day	\$600.00/day
Hospital Miscellaneous Expense limited to a maximum of	\$1,500.00	\$3,000.00
Hospital Emergency Care limited to a maximum of	\$200.00	\$400.00
Orthopedic Appliances furnished by the Hospital limited to a maximum of	\$100.00	\$200.00
Doctor's fees for surgery, in accordance with the Surgical Schedule using	\$75.00 per unit value	\$200.00 per unit value
Assistant Surgeon Expense, limited to	20% of the Surgical Schedule allowance	20% of the Surgical Schedule allowance
Anesthesia Services, limited to	20% of the Surgical Schedule allowance	20% of the Surgical Schedule allowance
Non-Surgical Doctors' Visits, including Physical Therapy: 1st Visit up to Thereafter up to Physical Therapy is limited to a maximum benefit of 5 visits.	\$25.00 \$15.00	\$60.00 \$50.00
Dental Treatment, per tooth (for Injury to Sound, Natural Teeth) limited to	\$200.00	\$600.00
X-ray: Fracture or dislocation, up to a maximum benefit of No fracture or dislocation, up to a maximum benefit of	\$200.00 \$50.00	\$500.00 \$150.00
MRI/CAT Scan, up to a maximum benefit of	\$200.00	\$500.00
Ambulance Expense, limited to a maximum of	\$100.00	\$400.00
Motor Vehicle Accident injuries, limited to	\$5,000.00	\$5,000.00
Loss of Life	\$5,000.00	\$5,000.00
Single Dismemberment – (Loss of One Hand, One Foot, Entire Sight of One Eye or Hearing One Ear)	\$1,000.00	\$1,000.00
Double Dismemberment – (Loss of both Hands, Both Feet, Entire Sight of Both Eyes, Hearing both Ears or Loss of Speech)	\$10,000.00	\$10,000.00
PREMIUMS (ONE-TIME ANNUAL PAYMENT)	STANDARD PLAN	DELUXE PLAN
<b>SCHOOL-TIME ACCIDENT COVERAGE</b>		
Students — Grades Pre-K - 8	\$23.00	\$52.00
Grades 9 - 12	\$46.00	\$105.00
<b>24-HOUR-A-DAY ACCIDENT COVERAGE</b>		
Students — Grades Pre-K - 12	\$125.00	\$275.00
<b>OPTIONAL FOOTBALL ONLY ACCIDENT COVERAGE</b>		
Per Player — Grades 9 - 12	\$162.00	\$369.00

- 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) or its representative (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the 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.

**To file a claim:** Report accidents to the school official. Simplified 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 the Plan Administrator 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.

Group Blanket Accident insurance products are issued on Form Series GP-2020 or GP-1200 by Guarantee Trust 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 of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

# 2018-2019 STUDENT ACCIDENT INSURANCE PLANS

## 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

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.

BENEFITS ARE PAYABLE UP TO THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		STANDARD PLAN	DELUXE PLAN	BENEFITS PER INJURY		STANDARD PLAN	DELUXE PLAN		
<b>HOSPITAL EXPENSE</b>	Room and board and general nursing care, per day	\$200	\$600	<b>AMBULANCE EXPENSE</b>	Limited to a maximum of	\$100	\$400		
<b>HOSPITAL MISCELLANEOUS EXPENSE</b>	Limited to a maximum of	\$1,500	\$3,000	<b>OUTPATIENT IMAGING PROCEDURES</b>	Fracture or dislocation	\$200	\$500		
					No fracture or dislocation Including x-rays and interpretation	\$50	\$150		
<b>HOSPITAL EMERGENCY CARE</b>	Limited to a maximum of	\$200	\$400	<b>DENTAL TREATMENT</b>	MRI/CAT Scan	\$200	\$500		
					Treatment for Injury to Sound, Natural Teeth, per tooth	\$200	\$600		
<b>DOCTOR'S FEES FOR SURGERY</b>	In accordance with the Surgical Schedule using:	\$75 Per Unit Value	\$200 Per Unit Value	<b>MOTOR VEHICLE ACCIDENT INJURIES</b>	Limited to a maximum of	\$5,000	\$5,000		
<b>ASSISTANT SURGEON EXPENSE</b>	Percent of the Surgical Schedule allowance	20%	20%						
<b>ANESTHESIA SERVICES</b>	Percent of the Surgical Schedule allowance	20%	20%	<b>OTHER BENEFITS</b> Caused by an Injury & occurring within 365 days of the covered Accident.  Only one of these benefits, the largest, will be payable in addition to other benefits listed.	<b>ACCIDENTAL DEATH DISMEMBERMENT</b>	\$5,000	\$1,000		
<b>DOCTORS' VISITS</b> Non-surgical Including Physical Therapy	First visit	\$25	\$60					Single: Loss of one hand, one foot, entire sight of one eye or hearing in one ear.	\$10,000
	Subsequent visits	\$15	\$50						
<b>ORTHOPEDIC APPLIANCES</b>	Furnished by the Hospital Limited to a maximum of	\$100	\$200						

### 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 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 by acts of war, whether declared or not.
- 4) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline.
- 5) Injury covered by Worker's Compensation or the Occupational Disease Law.
- 6) 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.
- 7) Re-injury or complications of an Injury which occurred prior to the Policy's Effective Date;
- 8) Hernia, any type, except if directly resulting from accidental Injury while covered under the Policy.
- 9) Injury sustained fighting or brawling, except as an innocent victim.
- 10) Injury sustained while voluntarily participating in a riot or civil commotion or disturbance of any kind.
- 11) Suicide or attempted suicide.
- 12) Treatment of sickness or disease in any form.
- 13) 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.
- 14) Injury sustained skiing or participating in a rodeo.
- 15) 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).
- 16) Injury sustained while participating in or practicing for tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased.
- 17) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body.
- 18) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- 19) 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.
- 20) Treatment of temporomandibular joint dysfunction and associated myofascial pain.
- 21) Injury sustained while committing or attempting to commit a felony, or while being engaged in an illegal occupation.

**EXCESS PROVISION:** All Covered Charges over \$100 will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance or Plan covers the Insured person. GTL will pay the first \$100 in Covered Charges regardless of other insurance.

Underwritten by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**, 1275 Milwaukee Avenue, Glenview, Illinois 60025

Administered by: **FIRST AGENCY**, 5071 West H Avenue, Kalamazoo, Michigan 49009-8501 (269) 381-6630

# 2018-19 SCHOOL YEAR ENROLLMENT FORM



PLEASE PRINT CLEARLY

ONE-TIME PREMIUM PAYMENT		
OPTIONS	STANDARD PLAN	DELUXE PLAN
<b>24-HOUR-A-DAY PLAN</b> Grades Pre K-12	<input type="checkbox"/> \$125	<input type="checkbox"/> \$275
<b>SCHOOL-TIME PLAN</b> Grades Pre K-8 Grades 9-12	<input type="checkbox"/> \$23 <input type="checkbox"/> \$46	<input type="checkbox"/> \$52 <input type="checkbox"/> \$105
<b>OPTIONAL FOOTBALL ONLY COVERAGE</b> (2018 Season only) Grades 9-12 Per Player	<input type="checkbox"/> \$162	<input type="checkbox"/> \$369
<b>NO REFUNDS ARE AVAILABLE</b>		

STUDENT'S NAME _____ <small style="display: flex; justify-content: space-between; width: 100%;"> <span>FIRST NAME</span> <span>MIDDLE INITIAL</span> <span>LAST NAME</span> </small>		
DATE OF BIRTH _____ <small style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>DAY</span> <span>YEAR</span> </small>		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
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:



**FIRST AGENCY**  
**5071 West H Avenue**  
**Kalamazoo, Michigan 49009-8501**



PLEASE NOTE: YOUR CANCELED CHECK IS YOUR RECEIPT. IF CANCELED CHECK IS NOT RECEIVED WITHIN 60 DAYS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR.

**For faster service you can pay by credit or debit card. Please visit us online at:**

**[www.1stagency.com/voluntaryaccidentcoverage.htm](http://www.1stagency.com/voluntaryaccidentcoverage.htm)**

**Follow directions by choosing STATE and SCHOOL DISTRICT**

**Visa and MasterCard are accepted**