Worried about paying for your child’s medical care if an accident should happen? K&K’s student accident insurance can help.

**K-12 Accident Plans available through your school:**
- At-School Accident Only
- 24-Hour Accident Only
- Extended Dental
- Football

**How to Enroll Online**
Enrolling online is easy and should take only a few minutes. Go to [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com) and click the “Enroll Now” button.

1. Start by telling us the name of the school district and state where your child attends school.
2. We’ll request each student’s name and grade level.
3. You’ll see the available plans and their rates. Select your coverage and continue to the next step.
4. We’ll request information about you, like your name and email address.
5. Next, you’ll enter information about the child or children to be covered.
6. Enter your credit card or eCheck payment information.
7. Finally, print out a copy of the confirmation for your records.

For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the policy may be continued in force, please refer to [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com). Student is able to purchase the coverage only if his/her school district is a policyholder with the insurance company.

¿Le preocupa tener que pagar la atención médica de su hijo si ocurre un accidente? El seguro contra accidentes para estudiantes de K&K puede ayudarlo.

**Planes de cobertura en caso de accidente para K-12 disponibles a través de su escuela:**
- Sólo accidentes en la escuela
- Sólo accidentes, 24 horas
- Dental extendido
- Fútbol

**Cómo inscribirse en línea**

1. Comience por decirnos el nombre del distrito escolar y el estado en el que su hijo(a) va a la escuela.
2. Solicitaremos el nombre y el grado de cada uno de los estudiantes.
3. Verá los planes disponibles y sus tarifas. Seleccione su cobertura y continúe con el siguiente paso.
4. Le solicitaremos información sobre usted, como su nombre y dirección de correo electrónico.
5. Después, ingresará la información acerca del niño o niños que recibirá(n) cobertura.
6. Ingrese la información de pago de su tarjeta de crédito o eCheck.
7. Finalmente, imprima una copia de la confirmación para sus registros.

Para obtener más detalles sobre la cobertura, incluidos costos, beneficios, exclusiones y reducciones o limitaciones y los términos en virtud de los cuales esta póliza podría continuar en vigencia, consulte [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com). Los estudiantes pueden comprar la cobertura únicamente si su distrito escolar es titular de una póliza con la compañía de seguros.
2023-2024 Student Accident Coverage

Served by: K&K Insurance Group, Inc.  Phone: 855-742-3135

Remember to visit our website for faster enrollment: www.studentinsurance-kk.com

Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.

ACCIDENT ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

SCHEDULE OF BENEFITS: Maximum Benefits Paid As Specified Below.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit:</td>
<td>$25,000 (For Each Injury)</td>
<td>$25,000 (For Each Injury)</td>
</tr>
<tr>
<td>Deductible:</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board Expenses: (Private/Semi-private room rate)</td>
<td>Up to $150 per day</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Miscellaneous Expenses</td>
<td>$600 maximum per day</td>
<td>$1,200 maximum per day</td>
</tr>
<tr>
<td>Physician’s Visits: (Limited to one visit per day)</td>
<td>$40 first day/$25 each subsequent day</td>
<td>$60 first day/$40 each subsequent day</td>
</tr>
<tr>
<td>Emergency Room Treatment:</td>
<td>$1,000 maximum</td>
<td>$1,200 maximum</td>
</tr>
<tr>
<td>(Treatment must be rendered within 72 hours from the time of the injury)</td>
<td>$150 maximum</td>
<td>$300 maximum</td>
</tr>
<tr>
<td>Surgery: (*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/ports.)</td>
<td>$1,000 maximum</td>
<td>$1,200 maximum</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</td>
<td>100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</td>
</tr>
<tr>
<td>Anesthesia and its Administration</td>
<td>100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</td>
<td>100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Physician Visits:</td>
<td>$40 first day/$25 each subsequent day</td>
<td>$60 first day/$40 each subsequent day</td>
</tr>
<tr>
<td>(Limited to one visit per day)</td>
<td>$200 maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>Outpatient X-ray:</td>
<td>$300 maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>Outpatient Diagnostic Imaging:</td>
<td>$300 maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>(CT Scan, MRI)</td>
<td>$50 maximum</td>
<td>$300 maximum</td>
</tr>
<tr>
<td>Outpatient Physiotherapy:</td>
<td>$30 first day/$20 each subsequent day/5 day maximum</td>
<td>$60 first day/$40 each subsequent day/5 day maximum</td>
</tr>
<tr>
<td>(Limited to one visit per day. Includes acupuncture; microtherapy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)</td>
<td>$300 maximum</td>
<td>$800 maximum</td>
</tr>
<tr>
<td>Ambulance Services: (Air and Ground)</td>
<td>$75 maximum</td>
<td>$140 maximum</td>
</tr>
<tr>
<td>Medical Equipment Rental:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes Orthopedic devices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000 maximum per policy term if extended dental option is purchased. $200 per tooth if extended dental option is not purchased.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$75 maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td>$200 maximum</td>
<td>$400 maximum</td>
</tr>
<tr>
<td>Replacement of Eye Glasses, Contact Lenses or Hearing Aids:</td>
<td>100% of Usual and Customary Charges</td>
<td>100% of Usual and Customary Charges</td>
</tr>
</tbody>
</table>

THIS IS A BLANKET ACCIDENT ONLY POLICY.

U.S. Insurance coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909, et al. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN; IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.
Choose Your Coverage Plan:  

**One-Time Payment For Accident Coverage**

**PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW**

**Coverage Effective Date:** A person’s coverage takes effect at the later of the date his or her completed student accident enrollment form and premium is received by the company or the effective date of the policy issued to his or her school or school district.

**Coverage Termination Date:** Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be an eligible person per the definition below. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

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### 24-Hour Accident (Students & Employees)

- Around-the-clock/anywhere in the world. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football

### 24-Hour Accident (Summer Only Coverage, Students Only)

- Summer begins on the first day after the school year ends.
- Summer ends the first day of the next school year.

### At-School Accident (Students & Employees)

- During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes. School sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.

### Extended Dental (Accident Only)

- Supplemental coverage extended to students with At-School, 24-Hour or Football Coverage – Limited to Covered Person’s policy effective dates and accident only coverage option selected. Replaces standard dental coverage with coverage of 80% of Reasonable Charges to a maximum limit of $10,000 per policy term.

### High School Football

- Play or practice of regularly scheduled football. Consult your Athletic Department for enrollment instructions.

### High School Football (Spring Only)

- For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.

### High School Football and At-School Accident (Covers all athletics)

### High School Football and 24-Hour Accident (Covers all athletics)

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### About Your Coverage

1. **ELIGIBLE PERSONS:** students of the policyholder who enroll and make the required premium contribution for the coverage selected are Eligible Persons under the Policy. Depending on the coverage selected, coverage may continue after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy is on file with the school district and is a non-renewable policy. The student coverage selected is non-renewable and requires the student to re-enroll each school year.
3. This is a limited benefit policy.
4. **COVERAGE EFFECTIVE DATE:** Insurance becomes effective for a student who enrolls and makes the required premium contribution on the latest of the following dates:
   a. the Policy Effective Date;
   b. the date the Company receives student’s completed enrollment form and the required premium payment.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

5. **COVERAGE TERMINATION DATE:** Coverage ends on the earlier of the date: he or she is no longer an Eligible Person, the end of the 1 year coverage term or the date the School’s policy ends. All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim for a Covered Accident that occurs before the termination date.

6. **LATE ENROLLMENT:** Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.

7. **CANCELLATION:** Your coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company.

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### Enroll online at:

**www.StudentInsurance-kk.com**

or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to AXIS Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child’s name on your check or money order.
4. Mail completed enrollment form with payment back to:

   **K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338**

5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

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### Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

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### Administered by:

K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338
COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane;
2. commission or attempt to commit a felony or assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased, operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. Injuries compensable under Worker's Compensation Law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in his Blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. participating as a professional in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
15. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury;
16. benefits will not be paid for services or treatment rendered by any person who is:
   a. employed or retained by the Policyholder;
   b. living in the Insured Person's household;
   c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
   d. the Insured Person.

EXCLUDED EXPENSES The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. repair or replacement of existing artificial limbs, eyes and larynx;
7. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.
In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits. Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENT ONLY DEFINITIONS:

Covered Injury means Accidental bodily injury:
1. which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force;
2. which results directly and independently from all other causes from a Covered Accident; and
3. which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident or Accidental: means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Medically Necessary: means medical services that:
1. are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. are ordered by a Physician and performed under His care, supervision or order.

Covered Loss must occur within 365 days of the Covered Accident. Not more than the Aggregate Limit of $500,000 will be paid for all Covered Losses. Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage. This Aggregate Limit is payable only once, should more than one Condition of Coverage apply. We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person’s loss to the total of all losses, multiplied by the Aggregate Limit.

<table>
<thead>
<tr>
<th>COVERED LOSS</th>
<th>BENEFIT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Two or More Hands or Feet</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Sight of Both Eyes</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Speech and Hearing (in Both Ears)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of One Hand or Foot and Sight in One Eye</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of One Hand or Foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Sight of One Eye</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Speech</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Hearing (in Both Ears)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Hearing in One Ear</td>
<td>$2,500</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger of the same Hand</td>
<td>$2,500</td>
</tr>
<tr>
<td>Exposure and Disappearance</td>
<td>Included</td>
</tr>
</tbody>
</table>
## Student Accident Enrollment Form (School Year 2023-2024)

### Student Insurance Plan Options — Check Your Selection:

<table>
<thead>
<tr>
<th>Accident Only Coverage Plans</th>
<th>Low Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-HOUR, with Extended Dental</td>
<td>$167.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>24-HOUR, without Extended Dental</td>
<td>$157.00</td>
<td>$241.00</td>
</tr>
<tr>
<td>24-HOUR, Summer Only, with Extended Dental</td>
<td>$41.00</td>
<td>$61.00</td>
</tr>
<tr>
<td>24-HOUR, Summer Only, without Extended Dental</td>
<td>$32.00</td>
<td>$51.00</td>
</tr>
<tr>
<td>AT-SCHOOL, with Extended Dental</td>
<td>$39.00</td>
<td>$53.00</td>
</tr>
<tr>
<td>AT-SCHOOL, without Extended Dental</td>
<td>$30.00</td>
<td>$43.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Full Year, with Extended Dental</td>
<td>$215.00</td>
<td>$347.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Full Year, without Extended Dental</td>
<td>$206.00</td>
<td>$338.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Spring Only, with Extended Dental</td>
<td>$91.00</td>
<td>$144.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Spring Only, without Extended Dental</td>
<td>$81.00</td>
<td>$135.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and AT SCHOOL, with Extended Dental</td>
<td>$254.00</td>
<td>$400.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and AT SCHOOL, without Extended Dental</td>
<td>$236.00</td>
<td>$381.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and 24-HOUR, with Extended Dental</td>
<td>$382.00</td>
<td>$597.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and 24-HOUR, without Extended Dental</td>
<td>$363.00</td>
<td>$579.00</td>
</tr>
</tbody>
</table>

### Enclose check for total payment payable to: AXIS INSURANCE COMPANY. Checks, money orders, or credit cards accepted.

**DO NOT SEND CASH**

**TOTAL ENCLOSED: $ __________________________**

### See IMPORTANT NOTICE - FRAUD WARNING on next page

Mail this completed form with payment back to: K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338
IMPORTANT NOTICE - FRAUD WARNING

- In General, and specifically for residents of Arkansas, Illinois, 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.

- For Residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.

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

- For residents of 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.

- For residents of the 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.

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

- For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- For residents of Maine, Tennessee and Washington: 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.

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

- For residents of 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.

- For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- For residents of 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 FINES AND CRIMINAL PENALTIES.

- For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- For residents of Ohio: 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.

- For residents of 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.

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

- For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

- For residents of 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.

- For residents of Virginia: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.
INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim
1. A school official will complete their portion and then give the claim form to the student’s or athlete’s parent(s)/guardian(s) for completion.
2. The student’s or athlete’s parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian
If you are attaching related medical bills, these bills must show the patient’s name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT’S PARENT(S)/GUARDIAN(S)

<p>| | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Student’s Name</td>
<td>Last:</td>
</tr>
<tr>
<td></td>
<td>First:</td>
<td>MI:</td>
</tr>
<tr>
<td>2.</td>
<td>Date of Birth:</td>
<td>SS#</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sex:</td>
</tr>
<tr>
<td>3.</td>
<td>Student’s grade in school:</td>
<td>Email address:</td>
</tr>
<tr>
<td>4.</td>
<td>Home Address Street:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Parent(s)/Guardian(s) Home Phone:</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Date of Accident:</td>
<td>Time of Accident:</td>
</tr>
<tr>
<td></td>
<td>Nature of Injury:</td>
<td>Describe exactly how accident happened:</td>
</tr>
</tbody>
</table>

6. Nature of activity and location during which the injury occurred (check all boxes which apply):
   - Pre-Kindergarten
   - High School
   - Interscholastic Sports
   - Club Sports
   - During Practice
   - Elementary School
   - Cafeteria
   - Intramural Sports, name of sport, if applicable:
   - Physical Education Class
   - During Play
   - Other Activity (specify) |
   - Middle School
   - Classroom Activities
   - Other Activity (specify) |
   - During Travel To or From the Event
   - Student
   - Volunteer
   - Cheerleader
   - Athletic Participant
   - Student/Manager
   - Other (specify) |

7. Transfer Student? | Yes | No |
If yes, please identify the former school name: |

8. Name, address and phone number of physician who first treated you: |   |   |   |
9. Have you had a similar injury in the past?  O Yes  O No
   If yes, describe and give dates: ___________________________________________

10. Name, address and phone number of physician who treated you for previous injury:
    ______________________________________________________________________

11. Are you covered by any other medical expense benefits plan?  O Yes  O No
    If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:
    ______________________________________________________________________

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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.

Date ______________________ Parent/Guardian Signature __________________________

SECTION II  (TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Student’s Name  Last: ___________________________ First: ___________________________ Mi: __________

2. Date of Accident ________________________________________________________________

3. Activity ________________________________________________________________

4. Nature of Injury ___________________________________________________________

5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT __________________________

6. Name of participating SCHOOL ______________________________________________

7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

   SIGNATURE OF SCHOOL OFFICIAL: ____________________________________________

   PRINTED NAME/TITLE: _______________________________________________________

   PHONE: ___________________________ FAX: ___________________________

   EMAIL: ___________________________ DATE: ___________________________

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

Date ______________________ Policyholder (School Official) Signature __________________________
IMPORTANT NOTICE

• In General, and specifically for residents of Arkansas, Illinois, 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.

• For Residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.

• For residents of 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.

• For residents of the 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.

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

• For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

• For residents of Maine, Tennessee and Washington: 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.

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

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

• For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

• For residents of 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 FINES AND CRIMINAL PENALTIES.

• For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

• For residents of Ohio: 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.

• For residents of 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.

• For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

• For residents of 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.

• For residents of Virginia: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

[AXIS_FRAUD 0220]

Dear Participant:
If you have an appointment with a doctor as a result of a sport related injury, please show this document to the doctor’s insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates.

The First Health Network

INSTURCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT/GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider’s bills for accident medical expenses as well as the primary carrier’s explanation of benefit showing their payment and denial. These bills must show the patient’s name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.

1675 AXIS 05/20
NAME OF CLAIMANT:  

INTERNATIONAL STUDENT O Yes O No

EMANCIPATED STUDENT: O Yes O No

OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No

NAME OF INSURED:

POLICY NO:

<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS FATHER DECEASED? O Yes O No</td>
<td>IS MOTHER DECEASED? O Yes O No</td>
</tr>
<tr>
<td>IS FATHER LEGALLY RESPONSIBLE? O Yes O No</td>
<td>IS MOTHER LEGALLY RESPONSIBLE? O Yes O No</td>
</tr>
<tr>
<td>FATHER'S NAME (if injured is a minor)</td>
<td>MOTHER'S NAME (if injured is a minor)</td>
</tr>
<tr>
<td>DATE OF BIRTH:</td>
<td>DATE OF BIRTH:</td>
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<tr>
<td>EMPLOYER NAME:</td>
<td>EMPLOYER NAME:</td>
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<tr>
<td>EMPLOYER ADDRESS:</td>
<td>EMPLOYER ADDRESS:</td>
</tr>
<tr>
<td>CITY:</td>
<td>CITY:</td>
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<tr>
<td>STATE:</td>
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<td>ZIP:</td>
<td>ZIP:</td>
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<td>PHONE:</td>
<td>PHONE:</td>
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<tr>
<td>CONTACT PERSON:</td>
<td>CONTACT PERSON:</td>
</tr>
<tr>
<td>Do you have group medical insurance coverage through your employment? O Yes O No</td>
<td>Do you have group medical insurance coverage through your employment? O Yes O No</td>
</tr>
<tr>
<td>If Yes, is it: O Individual O Family</td>
<td>If Yes, is it: O Individual O Family</td>
</tr>
<tr>
<td>If no, please be advised K&amp;K may contact your employer to verify no primary insurance is in force.</td>
<td>If no, please be advised K&amp;K may contact your employer to verify no primary insurance is in force.</td>
</tr>
<tr>
<td>INSURANCE COMPANY:</td>
<td>INSURANCE COMPANY:</td>
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<td>INSURANCE COMPANY ADDRESS:</td>
<td>INSURANCE COMPANY ADDRESS:</td>
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<td>POLICY NUMBER:</td>
<td>POLICY NUMBER:</td>
</tr>
<tr>
<td>TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO) O PREFERRED PROVIDER ORGANIZATION (PPO) O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE O OTHER (describe)</td>
<td>TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO) O PREFERRED PROVIDER ORGANIZATION (PPO) O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES O OTHER (describe)</td>
</tr>
</tbody>
</table>

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL. UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: PARENT/GUARDIAN/MOTHER SIGNATURE:

DATE: DATE:

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL, INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: SIGNED:

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

DATE: DATE:

1638 07/18
BLANKET ACCIDENT POLICY/CERTIFICATE AMENDMENT

POLICY AMENDMENT NO. 0000
POLICY RENEWAL

POLICYHOLDER: TELLURIDE SCHOOL DISTRICT R-1
DOING BUSINESS AS:
POLICY NUMBER: KAMV0000018091502
POLICY EFFECTIVE DATE: 08/01/23
POLICY ANNIVERSARY: 08/01
STATE OF ISSUE: CO

This Amendment is attached to and made part of the Policy effective 08/01/23 at 12:01 AM, Standard Time. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

It is hereby understood and agreed the Policy is renewed for a period of one year, commencing 08/01/23 and ending 08/31/24.

Renewal Premium: AS REPORTED

This Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Amendment.

The President and Secretary of AXIS Insurance Company witness this Amendment:

[Signatures]
Secretary

[Signature]
President