Student Insurance Plans
2012-2013

Why you need Student Insurance. . .

- Your school does not provide medical insurance to cover injuries to students. Instead, your school suggests this Plan to provide affordable coverage options.
- If you don't have other insurance, this Student Accident Plan is essential.
- Even if you do have other insurance, you will probably have to pay deductibles or co-payments. This Student Accident Plan will help to fill those expensive "gaps".
- Don't wait until you're faced with costly medical bills to think about insurance.

Read this brochure and make your selections today!

Choose from these school approved plans. . .

- Around-the-Clock Plan
- School Time-Only Plan

-plus-

- Extended Dental Plan
- Football Plan

UNDERWRITTEN BY:

MARKEL INSURANCE COMPANY

4600 COX ROAD
GLEN ALLEN, VA 23060

ADMINISTRATION OFFICE:

AMERICAN MANAGEMENT ADVISORS, INC.

PO BOX 366
LANGHORNE, PA 19047
(888) 533-7654

FORM-NH/VT **VERSION 37**

Choose from these School-Approved Plans:

Around-the-Clock Plan

The student is insured for full 24-hour a day protection, for school-connected accidents, and at home or away—at play—at camp—on vacation—scouting—amateur sports—youth group activities—or just playing in the neighborhood.

School Time-Only Plan

The student is insured while attending school when school is in session; participating in or attending activities sponsored solely by the school and supervised by a school official or employee, including all sports except interscholastic tackle football (unless you purchase football coverage) as well as travel by school-furnished transportation during the school term; traveling to or from the Insured's residence and the school for regular school sessions; and attending religious classes, including travel.

Football Coverage

Covers injuries caused by accidents occurring while participating in interscholastic tackle football played in or with grades 10-12, or while traveling as a team member in a school-provided vehicle to or from football games or practice, when such travel is sponsored by the school and supervised by school employees. 9th grade tackle football is covered under the School time-Only or Around-the-Clock Plans.

Extended Dental Plan

Increases the Dental Treatment Benefit for accidental Injury to sound natural teeth under the Plans to a maximum of $1,000.00 per tooth. This extended coverage is effective 24 hours a day even when selected with School time-Only Coverage and ends on the opening day of school for the following Fall term. Premium for the Extended Dental Benefit is $6.00 under all plans. Extended Dental Coverage may not be purchased by itself.

Additional facts about the Plans:

Effective and Expiration Dates: Applicants are covered as of the date the enrollment form and applicable premium are received by the school, but not prior to the first day of school. The expiration date of coverage under the School time-Only Plan is the close of the regular nine month school term, except while the Insured is attending academic classroom sessions, exclusively sponsored and solely supervised by the school during the summer; in such case coverage will terminate at the end of the summer classroom sessions. Around-the-Clock coverage ends on the opening day of school for the following Fall term. Football Coverage starts the first day of authorized practice, provided premium is paid prior to that date, and expires 7-1-13.

Student Accident Insurance covers accidental bodily Injury sustained during the term of insurance and which causes loss directly and independently of all other causes. Insurance is good anywhere. For example, if the student buys the Plan at school and the family moves, coverage will continue until the close of the school term at any new public or parochial day school. There is no limit to the number of accidents a student can have paid under this Policy.

AD&D Benefits

For Loss of:

Life	$ 2,000
Both hands or both feet or both Eyes	10,000
One hand and one foot, one hand and one eye or one foot and one eye	4,000
One hand or one foot	2,000
One eye	1,500

If within 100 days from the date of a covered accident, injuries cause dismemberment or death, the largest applicable indemnity will be paid, in addition to benefits for medical expense.

IMPORTANT NOTICE

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary state approvals. Any provision of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits. This plan is not available in all states. Benefits for covered expenses, listed under the BENEFITS UNDER THE PLANS, will not exceed the specified amounts.

Your choice of benefits

The Policy will pay up to $50,000.00 for covered expenses incurred as the result of Accidental Bodily Injury sustained in any one Accident that occurs on or after the effective date of coverage. This first such expense must be incurred within 30 days of the accident and the covered treatment, care or service rendered within 52 weeks of the accident. Benefits for covered expenses shall not exceed the specified amounts. The first $100 of covered expenses incurred as a result of each covered accident claim will be paid, regardless of any other insurance. If expenses exceed $100, the claim will then be paid on an ***AN EXCESS BASIS, if other insurance or medical service plans are involved (see LIMITATIONS). All benefits are per accident, unless otherwise specified.

	Elite Plan	Superior Plan	Economy Plan
Policy Maximum per covered accident	$50,000.00	$25,000.00	$25,000.00
Medical Treatment by a licensed physician, except in connection with surgery or for physiotherapy as defined below	80% of U&C**	$50.00 per treatment	$25.00 per treatment
Surgery by a licensed physician (Payable according to CRVS* or U&C**)	80% of U&C Max. $8,000.00	$175.00 unit value	$125.00 unit value
*Example Osteotomy Fibula	N/A	$735.00	$525.00
Anthroplasty Ankle	N/A	$1,872.50	$1,337.50
Anesthesiologist (percent of surgery allowance)	25%	25%	25%
Assistant Surgeon (percent of surgery allowance)	20%	20%	20%
Inpatient Hospital Care and Service when the Insured is confined as an overnight resident patient for room and board (except for hospital intensive care)	Semi-Private Room Rate	$400.00 per day	$200.00 per day
For hospital intensive care room and board	$1,000 per day	$400.00 per day	$200.00 per day
For ancillary medical expenses, including radiology and diagnostic imaging as provided below	$2,000.00	$1,500.00	$1,000.00
Outpatient Hospital Care and Service treatment at a hospital emergency room or outpatient department, in addition to benefits for physician's treatments and radiology and diagnostic imaging as provided	$300.00	$150.00	$100.00
Outpatient Surgical Facility room and supplies	$900.00	Paid as Outpatient Hospital Care	Paid as Outpatient Hospital Care
Radiology (excluding MRI's and Cat Scans),including reading and interpretation but excluding dental X-rays and X-rays in connection with physiotherapy	80% of U&C to $250.00	$180.00	$90.00
Diagnostic Imaging (MRI's, Cat Scans, etc.)	80% of U&C to $800.00	$400.00	$200.00
Nurse Service upon recommendation of the attending physician, provided by a private duty R.N. or L.P.N. not a member of the Insured's family or household	U&C	U&C	U&C
Dental Treatment for accidental Injury to one or more sound natural teeth including charges for braces, crowns, jackets, inlays, fillings, bridges, and root canal therapy	$400 per tooth	$350.00 per tooth	$175.00 per tooth
Professional Ambulance Service from the place of accident to a hospital	$500.00	$250.00	$125.00
Physiotherapy by a licensed practitioner, including diathermy, heat treatment, adjustment, manipulation, or massage, when medically necessary	$50.00 per visit max 5 visits	$40.00 per visit max 5 visits	$20.00 per visit max 5 visits
Orthopedic Appliances when ordered by the attending physician	$250.00	$150.00	$75.00
Eyeglasses, contact lenses, and hearing aid replacement, when medical treatment is required for a covered accident	$200.00	$50.00	$25.00

*"CRVS" is the California Relative Value Studies, Fifth Edition.
**"U&C" means usual and customary charges in the area where the treatment or service is provided.

Conformity with State Statutes

Any provision of this plan of insurance which, on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

Any Expense not specifically listed in the preceding sections is not covered.

Exclusions

The policy does not cover Loss nor provide benefits for: (a) Expenses for dental treatment, except for treatment resulting from Injury to natural teeth; as specifically provided; (b) Services normally provided without charge by the Policyholder's health service, infirmary, Hospital or employees; (c) Routine eye exams and contacts; replacing eyeglasses or prescription therefore; routine examinations and services related to hearing examinations or hearing aids; or treatment for hearing defects not related to an Injury; (d) Routine physical examinations; preventive care; elective surgery and elective treatment; services solely to improve appearance; for personal hygiene; services specially for dietary control; custodial, sanitarial or rest care; (e) Cosmetic Surgery. (f) Skydiving; recreational parachuting; hang gliding; glider flying; parasailing; sail planing; bungee jumping; or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; (g) Injury resulting from any declared or undeclared war; (h) Injury due to participation in a riot; com- mission of or attempt to commit a felony; il) Suicide, attempted suicide or intentionally self-inflected Injury; (m) Injury while in the armed forces of any country. (j) Injury covered by any workers' compensation or occupational disease law; (k) Injury resulting from being under the influence of alcohol or drugs unless taken on a Physician's advice; (l) Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges; or (m) Pre-Existing Conditions.

To File A Claim:

1. To download a claim form, go to: www.amastudentplans.com/downloads/K-12_MKL.pdf
2. Fill out parts A and B
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

All Claims must be filed within One (1)Year of the Date of Service or as soon as reasonably possible.

ENROLLMENT FORM CHECKLIST

Did You:

❒ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)

❒ Check the appropriate box(s) for the coverage you have selected.

❒ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

For questions, inquiries, and information contact:

American Management Advisors, Inc.
PO Box 366
Langhorne, PA 19047
(888) 533-7654
(215) 946-8888

How to apply

- Choose the plan best suited to your needs.
- Complete and sign the attached enrollment form. Enclose check or money order payable to American Management Advisors, Inc. for the required yearly premium.
- Return the sealed envelope to American Management Advisors, Inc.

IMPORTANT Keep this brochure as a Summary of Benefits. The Policy is on file at your school. It is subject to Insurance Department approval and will conform to the laws of the state where your school is located. Individual policies will not be sent to you.

LATE ENROLLMENT Coverage may be purchased at any time during the school year, but there is no premium reduction for late enrollment.

CANCELLATION Coverage is not able to be cancelled and premiums will not be pro-rated or refunded.

RETURN OF CHECK BY BANK Coverage will be immediately invalidated if check is returned by bank for any reason.

Do not send cash

Enrollment Form

Enrollment Form

Please print child's name clearly--1 letter to a box

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

GRADE BIRTHDATE (Mo/Day/Yr) Social Security Number

PARENT'S NAME _____

HOME ADDRESS _____
No. & Street Apt. #

_____ ( )
City State Zip Phone #

NAME OF SCHOOL _____

SCHOOL DISTRICT OR ADDRESS (CITY) _____
City State

SIGNATURE _____
(Parent or Guardian) Date Signed

Yearly Student Rates – 2012-2013 Check your Selections

COVERAGE OPTIONS	BENEFIT OPTIONS ❑ Elite Plan	❑ Superior Plan	❑ Economy Plan
Around-the-Clock Accident Coverage	❑ $140.00	❑ $98.00	❑ $62.00
Schooltime-Only Accident Coverage	❑ $39.00	❑ $27.00	❑ $16.00
*Extended Dental	❑ $6.00	❑ $ 6.00	❑ $6.00
Football-Only	❑ $198.00	❑ $143.00	❑ $84.00
Total Payment Enclosed	$	$	$

***Note: Extended Dental Coverage is available only in combination with Around-the-Clock or Schooltime-Only Coverage.**

Make Check or Money Order Payable to
American Management Advisors, Inc.
DO NOT ENCLOSE CASH

❑ I DO NOT WISH TO PURCHASE INSURANCE AT THIS TIME

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement may be guilty of insurance fraud.

Return Completed form to:
MCA Administrators, Inc.

P.O. Box 6540
Harrisburg, PA 17112
P:800-427-9308 | **F**:717-652-8328

K12 Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.
4. Social Security Number is necessary for Federal Reporting.

Part 1 - POLICYHOLDER'S REPORT

Name of School	Name of Policyholder				Policyy Number
Claimant's Name (Injured Person)	Social Security Number	Gender ☐ Male ☐ Female	Date of Birth		Email Address
Claimant's Address		City	State	Zip	Phone Number
Parent's Name (if applicable)	Parent's Address (if applicable)	City	State	Zip	Phone Number

1. Date and time of the accident: _____ Place where the accident occurred: _____

2. Was the injured person? ☐ Student ☐ Interscholastic Sports

FOR DENTAL CLAIMS ONLY

3. Indicate which teeth were involved in the accident: _____

4. Describe condition of injured teeth prior to accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

5. Nature of injury: _____
(Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.)

6. Describe how the accident occurred - give all possible details - must be a bodily injury due to accident:

_____

7. Did the accident occur?

A. During a policyholder sponsored & supervised activity? ☐ Yes ☐ No
B. During programmed hours? ☐ Yes ☐ No
C. On activity premises? ☐ Yes ☐ No
D. While traveling directly to or from a sponsored event? ☐ Yes ☐ No

8. Name of the event or activity: _____ Name and Title of Supervisor: _____

9. Representative Signature _____ Title _____ Date _____

Part 2 - OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage through an employer or other source on you? ☐ Yes ☐ No

If Yes, Name of insurance company _____ Policy # _____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐ Yes ☐ No

If Yes, Name of insurance company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse Markel Insurance Company to the extent of any amount collectible.

Signature: _____ **Witness:** _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative's Signature: _____ **Date:** _____

If Authorized Representative, Relationship to Patient or Legal Designation: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.
I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative's Signature: _____ **Date:** _____

If Authorized Representative, Relationship to Patient or Legal Designation: _____

PLEASE NOTE:

In furnishing this or other claim forms fro the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any 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: 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 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.

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 RESIDENTS: 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 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim 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: Any 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.

LOUISIANA: 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.

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 fines and criminal penalties.

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.

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.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

VIRGINIA: 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.

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.