

2016-2017 STUDENT INSURANCE PLANS

WE RECOMMEND 24-HOUR-A-DAY COVERAGE

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident insurance plans to 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-HR-A-DAY	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	BECOMES EFFECTIVE THE DATE PREMIUM PAYMENT IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE (but not prior to the opening day of school).
✓	✓	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 THE COMPANY, 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.

PROTECT YOUR CHILD FOR LIFE

Life Insurance for your Child

FOR NOW AND THROUGHOUT THEIR GROWING YEARS, THE GREAT START PLAN PROVIDES ALL THE BASIC LIFE INSURANCE YOU NEED ON YOUR CHILD...UP TO \$10,000. FOR THEIR FUTURE...DEPENDING ON YOUR ORIGINAL POLICY, YOUR ADULT CHILD CAN INCREASE THEIR ORIGINAL \$10,000 COVERAGE TO A FULL \$40,000. JUST CHECK (✓) THE BOX FOR LIFE INSURANCE AND SELECT THE AMOUNT YOU WANT FOR YOUR CHILD AS YOU SIGN UP FOR ACCIDENT PROTECTION. YOUR CHILD IS FULLY INSURED FROM THE DAY YOUR POLICY IS APPROVED AND ISSUED. THE ONLY EXCLUSION IS SUICIDE IN THE FIRST 2 YEARS (1 YEAR IN CO AND ND, N/A IN MO). THIS POLICY PROVIDES BASIC LIFE INSURANCE UNTIL YOUR CHILD REACHES AGE 25. AT AGE 25, THE POLICY CONTINUES AS CASH VALUE WHOLE LIFE INSURANCE. CHILDREN AGES 3 MONTHS TO 24 YEARS ARE ELIGIBLE TO APPLY. SIMPLY COMPLETE AND SIGN THE APPLICATION FORM. POLICIES ARE AVAILABLE FOR \$5,000 AND \$10,000 BENEFIT AMOUNTS. THE RATES ARE \$20 A YEAR FOR A \$5,000 POLICY AND \$40 A YEAR FOR A \$10,000 POLICY. AT AGE 25, THE RATES CHANGE TO \$93 PER YEAR FOR A \$5,000 POLICY AND \$186 PER YEAR FOR A \$10,000 POLICY. THESE RATES ARE GUARANTEED TO REMAIN THE SAME FOR LIFE.



Why not take a positive step to PROTECT YOUR CHILD FOR LIFE? \$1 for the first 3 months. APPLY TODAY!

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 COMPANY WITHIN 90 DAYS.

Accident Insurance

24-Hour-A-Day Coverage

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

Protects 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 Coverage

Your child is protected while attending regular school sessions. Also covered is 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.

Blanket Accident insurance is issued on Form Series GP-2020 by Guarantee Trust Life Insurance Company. This product, and its features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. This brochure is a brief description of the coverage. For complete details of coverage please contact the agent administering the program.

2016-2017 STUDENT 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.

COVERAGE & BENEFITS

BENEFITS ARE PAYABLE UP TO THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		STANDARD PLAN	DELUXE PLAN	BENEFITS PER INJURY		STANDARD PLAN	DELUXE PLAN
HOSPITAL EXPENSE	Room and board and general nursing care, per day	\$200.00	\$600.00	ORTHOPEDIC APPLIANCES	Furnished by the Hospital limited to a maximum of	\$25.00	\$50.00
HOSPITAL MISCELLANEOUS EXPENSE	Limited to a maximum of	\$1,500.00	\$3,000.00	AMBULANCE EXPENSE	Limited to a maximum of	\$100.00	\$400.00
HOSPITAL EMERGENCY CARE	Limited to a maximum of	\$200.00	\$400.00	X-RAY	Fracture or dislocation	\$200.00	\$500.00
DOCTOR'S FEES FOR SURGERY	In accordance with the Surgical Schedule using:	\$75.00 Per Unit Value	\$200.00 Per Unit Value		No fracture or dislocation	\$50.00	\$150.00
ASSISTANT SURGEON EXPENSE	Percent of the Surgical Schedule allowance	20%	20%	MRI/CAT SCAN		\$200.00	\$500.00
ANESTHESIA SERVICES	Percent of the Surgical Schedule allowance	20%	20%	DENTAL EXPENSE	Treatment for Injury to Sound, Natural Teeth, per tooth	\$200.00	\$600.00
DOCTORS' VISITS Non-surgical Including Physical Therapy	First visit Subsequent visits Physical Therapy is limited to 5 visits	\$25.00 \$15.00	\$60.00 \$50.00	MOTOR VEHICLE ACCIDENT INJURIES	Limited to a maximum of	\$5,000.00	\$5,000.00
				OTHER BENEFITS	ACCIDENTAL DEATH	\$5,000.00	
				Caused by an Injury and occurring within 365 days of the covered Accident. Only one of these benefits, the largest, will be payable in addition to other benefits listed.	DISMEMBERMENT	\$1,000.00	
					Single: Loss of one hand, one foot, entire sight of one eye or hearing in one ear.	\$10,000.00	
					Double: Loss of both hands, both feet, sight of both eyes, hearing in both ears or loss of speech.		

This is an illustration of your child's benefits. Please keep for your records. This is not a contract. The master policy is on file with your school.

EXCLUSIONS: THE POLICY DOES NOT COVER:

1. Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy;
2. Intentionally self-inflicted Injury. Injury by acts of war, whether declared or not;
3. Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline;
4. Injury covered by Worker's Compensation or the Occupational Disease Law;
5. 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;
6. Re-injury or complications of an Injury which occurred prior to the Policy's Effective Date;
7. Hernia, any type, except if directly resulting from accidental Injury while covered under the Policy;
8. Injury sustained fighting or brawling, except as an innocent victim;
9. Injury sustained while voluntarily participating in a riot or civil commotion or disturbance of any kind;
10. Suicide or attempted suicide;
11. Treatment of sickness or disease in any form;
12. Loss resulting from the use of any drug or agent classified as a narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor;
13. Injury sustained skiing or participating in a rodeo;
14. 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);
15. Injury sustained while participating in or practicing for tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased;
16. Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body;
17. Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay;
18. 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;
19. Treatment of temporomandibular joint dysfunction and associated myofascial pain;
20. 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. The Company will pay the first \$100 in Covered Charges regardless of other insurance.

Underwritten by: **GUARANTEE TRUST LIFE INSURANCE COMPANY**, Home Office, Glenview, Illinois 60025
Administered by: **FIRST AGENCY**, 5071 West H Avenue, Kalamazoo, Michigan 49009-8501 (269) 381-6630

2016-17 SCHOOL YEAR APPLICATION

ONE-TIME PREMIUM PAYMENT FOR ACCIDENT PLANS		
OPTIONS	STANDARD PLAN	DELUXE PLAN
24-HOUR-A-DAY COVERAGE GRADES PRE K-12	<input type="checkbox"/> \$125.00	<input type="checkbox"/> \$275.00
SCHOOL-TIME COVERAGE GRADES PRE K-8 GRADES 9-12	<input type="checkbox"/> \$23.00 <input type="checkbox"/> \$46.00	<input type="checkbox"/> \$52.00 <input type="checkbox"/> \$105.00
OPTIONAL FOOTBALL COVERAGE (2016 Season only) Per Player - Grades 9-12	<input type="checkbox"/> \$162.00	<input type="checkbox"/> \$369.00
NO REFUNDS ARE AVAILABLE FOR ACCIDENT PLANS		
GREAT START* Life Insurance Protection <input type="checkbox"/> \$1.00 For first 3-months full coverage (May be selected with or without other plans) Pick an Amount <input type="checkbox"/> \$ 5,000.00 <input type="checkbox"/> \$10,000.00		

Student Accident Insurance Application

PLEASE PRINT CLEARLY

School _____ District _____ Grade _____

Person to be insured _____

First Name M Last Name

Address _____
No. and Street City State Zip Code

Age _____ Date of Birth _____ Male Female Phone No. () _____
Month Day Year

***COMPLETE THIS SECTION IF A MODIFIED WHOLE LIFE POLICY WITH 3 MONTHS PRELIMINARY TERM IS DESIRED.**

Mail Policy and Premium Notice to: _____
First Name Middle Initial Last Name

Has the person to be insured, within the last 5 years, had or received medical treatment or advice for: high blood pressure, heart trouble, cancer or tumor, kidney trouble, diabetes, epilepsy, birth defects, drug or alcohol abuse or a sexually transmitted disease?..... No Yes

Within the past 5 years, has the person to be insured been diagnosed by a medical doctor as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the presence of the Human Immunodeficiency Virus (HIV)?..... No Yes

Is this insurance meant to replace any existing insurance or annuities with any company?..... No Yes

If answer is yes, list company name and address. _____

To the best of my knowledge and belief, the above answers are true and correct. I understand that I am the Policy's Owner and Beneficiary, unless another Beneficiary is named. I also understand the insurance is not effective until October 15, 2016, or the date the application is received by the company or its representatives, if later. Any life insurance premium will be refunded if the policy is not issued.

Date _____ Signature _____

APP4-96

Relationship to Insured:	
<input type="checkbox"/> Self	<input type="checkbox"/> Grandparent
<input type="checkbox"/> Guardian	<input type="checkbox"/> Parent

TOTAL ENCLOSED \$ _____
 (Please do not send cash)

MAKE CHECK PAYABLE TO: **FIRST AGENCY**

TO PAY BY CREDIT/DEBIT CARD PLEASE VISIT:

www.1stagency.com/voluntaryaccidentcoverage.htm

L-25

PLEASE REMEMBER TO:



COMPLETE THE APPLICATION 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 APPLICATION 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

Follow directions by choosing STATE and SCHOOL DISTRICT

Visa and MasterCard are accepted

ILLINOIS 2016/2017

Policy 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	\$25.00	\$50.00
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 PAYMENT)	STANDARD PLAN	DELUXE PLAN
SCHOOL-TIME ACCIDENT COVERAGE		
Students — Grades Pre-K - 8	\$23.00	\$52.00
Grades 9 - 12	\$46.00	\$105.00
24-HOUR-A-DAY ACCIDENT COVERAGE		
Students — Grades Pre-K - 12	\$125.00	\$275.00
OPTIONAL FOOTBALL ONLY ACCIDENT COVERAGE		
Per Player — Grades 9 - 12	\$162.00	\$369.00