



**THE
HARTFORD**

Nobody Plans on Having an Accident

But if one happens while at school,
you should have a cost effective
student voluntary insurance plan.

STUDENT ACCIDENT INSURANCE ENROLLMENT FORM

Coverage is underwritten by Hartford Life and Accident Insurance Company – Fill out completely. Please Print Clearly.

Easy One Time Payment
(Check or Money Order)

SCHOOL TIME BASE COVERAGE

\$45.00

OPTIONAL FOOTBALL COVERAGE (Grades 7-12)

\$235.00 ** MUST also purchase School Time **

OPTIONAL 24-HOUR ACCIDENT COVERAGE

\$130.00 ** MUST also purchase School Time **

OPTIONAL EXTENDED DENTAL COVERAGE BENEFIT

\$13.00 ** MUST also purchase School Time **

Please make check payable to Bene-Marc, Inc.

(PLEASE DO NOT SEND CASH)

**Mail Enrollment Form and Payment to:
Bene-Marc, Inc.**

**6301 Southwest Blvd., Ste. 101
Ft. Worth, TX 76132**

School District

School Name

Student First Name

Middle Initial

Last Name

Street Address

City

State

Zip

Phone Number(s)

Grade

Date of Birth (MM/DD/YYYY)

Signature (Parent/Guardian)

Date

PLEASE NOTE: Proof of enrollment will be provided after check or money order is received. The master policy will be on file with the School District. Please keep this brochure to refer to Benefits & Provisions when needed.

STUDENT ACCIDENT INSURANCE PLAN

Up to the maximum benefit of the plan selected will be paid for the covered injuries (including heat stroke, heat exhaustion, or heat related injuries) sustained in any one accident which occurs on or after the effective date of coverage. The following treatment, care and services must occur within 26 weeks after the date of accident, and not exceed the specified amounts, provided that the first treatment is incurred within 90 days after the date of accident. Payment will be coordinated for expenses as EXCESS per accident for which any other collectible insurance is collectible, including HMO'S, PPO's, Workers' Compensation and automobile No-fault insurance.

BENEFITS PROVIDED AND COVERAGE AMOUNTS

Voluntary Student Accident Insurance Plan – Texas K-12 School Time – 24 Hour Coverage for Injuries due to Accident only.

Voluntary plan. Medical benefits are paid for expenses which are incurred within 52 weeks from the date of the covered injury, provided that treatment is received with 26 weeks of injury. Accidental Death & Dismemberment losses must occur within 180 days after date of Accident causing such loss. Payment is made for Reasonable and Expenses if the treatment is determined by a Physician to be Medically Necessary and will be subject to all terms and conditions under the Policy. All benefits are paid on a per-injury basis.

Accident Medical Expense Benefit (School Time, Football, and 24-hour)	\$25,000
Deductible	\$0
Motor Vehicle Injuries	\$5,000
Death Benefit	\$5,000 Principal Sum
Dismemberment Benefit	\$5,000 Principal Sum
Physician's Office Visit Treatment (Other than a Surgeon)	\$10 per visit/\$100 maximum
Surgeon Expenses - Refer to attached Surgical Schedule for examples	Paid in Accordance with surgical schedule 80 Per-Point Value to \$800 Maximum (Only one Surgery covered per incision)
Anesthesiologist Expenses (Only if Surgeon is Paid)	25% of Surgery Benefit Paid
Assistant Surgeon (Only if Surgeon is Paid)	25% of Surgery Benefit Paid
Hospital-ICU Room & Board (Both paid as Hospital Semi-Private Room)	\$200 per day
Hospital Inpatient Miscellaneous Expense (Including Radiology and Diagnostic imaging as provided below)	\$250 1 st Day \$100 per day thereafter \$2,000 Maximum
Hospital Outpatient Emergency Room Physician	\$30 Maximum
Outpatient Hospital Care and Service treatment at a hospital emergency room or outpatient department, including lab, in addition to benefits for Physician's treatment and radiology and diagnostic imaging as provided	\$60 Maximum
Hospital Outpatient Surgical Facility (other than ER)	\$500 Maximum
X-Rays – Outpatient including Interpretation	\$60 Maximum
Diagnostic Imaging - Outpatient (CT/MRI, including interpretation)	\$200 Maximum
Registered Nurse's Services (does not include anesthesiology)	\$100 Maximum
Dental Treatment (Injury to sound, natural teeth only)	\$50 Maximum per tooth
Extended Dental Coverage (optional coverage - additional \$8)	\$500 Maximum per tooth

Professional Ambulance – Ground Transport Only (one trip Per injury from Accident scene to hospital)	Usual & Customary \$80 Maximum
Orthopedic Appliances/Durable Medical Equipment (when ordered by Attending physician)	\$100 Maximum
Outpatient Prescription Drugs	\$25 Maximum
Replacement of Eye Glasses, Contact Lenses & Hearing Aids (only when medical treatment is also required for a covered injury)	\$50 Maximum
Chiropractic Treatment by licensed physician or therapist for covered losses only (Inpatient & Outpatient)	\$20 per visit/ \$100 Maximum
Physical Therapy for covered Losses only (Inpatient & Outpatient)	\$100 Maximum
Expanded Medical Benefit	Up to \$300 per injury
Field Trip Benefit	Up to \$1,500 per injury

COVERAGE OPTIONS

School Time Accident Coverage

- On the grounds of the school (including the parking lot) during normal school days. Extracurricular and club activities are included.
- Traveling at any time on a bus operated for the purpose of transporting Insured Persons for school sponsored activities.
- Participating in all school sponsored athletic/UIIL activities (excluding Football, Grades 7-12), including regularly scheduled practice sessions, games, tournaments, events located at other schools, and/or travel directly to and from athletic events.
- School sponsored field trips are covered for all Insured Persons.

Optional Additional Coverages

Optional Football coverage (Grades 7-12)

Participating in school sponsored athletic/UIIL activities, including regularly scheduled practice sessions, games, tournaments, events located at other schools, and/or travel directly to and from athletic events.

Optional 24-hour Accident Coverage

Participating in around the clock, non-school related activities resulting in accidental injuries. Note: 24-hour accident coverage is not intended to provide benefits for Football injuries, Grades 7-12.

Optional Extended Dental Coverage Benefit

By adding an additional \$13 premium to the \$45 base plan rate, dental benefits may be extended under the overall maximum benefit to provide payment of covered expenses to a maximum of \$500.00 per tooth. The additional benefit provides payment for the usual and customary expenses.

EFFECTIVE & TERMINATION DATE

Effective Date: Each person becomes an Insured Person on the date he or she meets the qualifications stated in the Schedule. For voluntary coverage, if an enrollment form and premium is received within 31 days of the policy effective date, coverage will be effective for the individual on the policy effective date. If an enrollment form is received greater than 31 days after the policy effective date, then individual coverage will begin on the date the

Hartford receives both the enrollment form and premium for the individual. The Hartford will not refund premium on a pro-rata basis for premiums that are paid after 31 days past the policy effective date.

Termination Date: Coverage of each Insured Person ceases on the first to occur of:

- (a) the date the Policy terminates; or
- (b) the date he or she ceases to qualify as an Insured Person.

Termination shall be without prejudice to any claim for loss due to an accident that occurs before the termination date.

EXCLUSIONS

The Policy does not cover loss resulting from or for:

1. intentionally self-inflicted Injury, suicide, or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while in the armed forces (land, water or air) of any country or international authority;
4. Injury sustained while in or on, boarding or alighting from, being struck or run down by, any aircraft except as an airline passenger on an aircraft: (a) operated by a passenger airline on a regularly scheduled trip over its established route or that is chartered by that airline; or (b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States or any national government recognized by the United States;
5. dental work or treatment on natural teeth which is not necessary for the repair or relief of Injury;
6. repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration;
7. repair or replacement of artificial limbs or orthopedic braces;
8. Injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
9. Injury sustained while the Insured Person is voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless the drug is taken as prescribed or administered by a licensed Physician;
10. Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
11. Injury sustained as a result of the Insured Person's being legally intoxicated from the use of alcohol while operating a motor vehicle;
12. Expenses incurred for services, treatment, supplies or facilities rendered by: (a) the Policyholder's health service or infirmary; or (b) any Physician or nurse employed or retained by the Policyholder;
13. Expenses covered under any automobile reparations insurance (no-fault) or automobile insurance medical payments benefit.

HOW TO FILE A CLAIM

Proof of loss must be sent to us within 90 days after the date of the loss. If the claimant is not able to send proof within that time it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Please submit claims under the student accident insurance policy to:

Fringe Benefit Coordinators P O Box 5249, Gainesville, FL 32627

A copy of the bills and expenses incurred should be attached to a claim for m and forwarded promptly, when available.

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Injury means bodily injury of an Insured Person that results directly and independently of all other causes from an accident which occurs while he or she is participating in a Covered Activity. Loss resulting from sickness or disease, except a pus-forming infection that occurs through an accidental wound, is not considered as resulting from Injury.

Policy form No.: SRP-1400 (HLA) HPP

Brochure No.: CV0814-4

5230 NS 05/14 SRP-1400 (HLA)

Underwritten by:

Hartford Life and Accident Insurance Company

QUESTIONS?

Call the Marketing Agent:

BENE-MARC, INC.

6301 Southwest Blvd., Suite 101

Fort Worth, TX 76132

817-738-6899

Texas License # 12743

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. This brochure/presentation explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability.