GTL GUARANTEE TRUST LIFE 2022-2023 STUDENT ACCIDENT INSURANCE PLANS

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Guarantee Trust Life Insurance Company (GTL), its representatives or school officials (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the Ohio High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

Optional Football Only Accident Coverage begins on the date of premium receipt by GTL, its representatives or school officials, but not prior to the first official date of practice; and continues through the date of the last official game of the current season including playoffs.
Football premium covers football only.

To file a claim: Report accidents to the school. 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 Guarantee Trust Life Insurance Company within 90 days.

24-HOUR-A-DAY ACCIDENT COVERAGE

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

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY.** This includes covered accidents:

At home · At play · At school · On vacation · Scouting, camping etc. · During covered travel

While engaged in sports, except those specifically excluded or for which optional coverage is required*

***See OPTIONS for available optional sports coverage, if any.**

SCHOOL-TIME ACCIDENT COVERAGE

Helps protect your child while attending regular school sessions. Includes coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

Blanket Accident insurance products are issued on Form Series GP-2030, GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

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

Coverage and Benefits

BENEFITS ARE PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER INJURY		Low Option	High Option
HOSPITAL ROOM AND BOARD AND GENERAL NURSING CARE	Per day	**$150**	**$300**
HOSPITAL MISCELLANEOUS EXPENSE		**$1,000**	**$2,000**
HOSPITAL EMERGENCY CARE		**$150**	**$300**
DOCTOR'S FEES FOR SURGERY	Per Unit Unit Value determined by the Surgical Schedule	**$80**	**$160**
ANESTHESIA SERVICES	Percent of Surgical Schedule Allowance	**25%**	**25%**
AMBULANCE EXPENSE		**$100**	**$200**
DOCTORS' VISITS **Non-surgical** Including Physical Therapy	Per visit	**$25**	**$50**
	Physical Therapy, per visit	**$25**	**$50**
	Maximum number of visits per Injury	**3**	**3**

BENEFITS PER INJURY		Low Option	High Option
IMAGING PROCEDURES	Including X-rays and interpretation	**$100**	**$200**
MRI/CAT Scan		**$125**	**$250**
ORTHOPEDIC APPLIANCES	Furnished by the Hospital	**$100**	**$200**
DENTAL TREATMENT	For Injury to Sound, Natural Teeth, per tooth	**$200**	**$400**
	Up to a maximum of	**$600**	**$1,200**
ACCIDENTAL DEATH AND DISMEMBERMENT Only one of these benefits, the largest, will be payable in addition to other benefits shown	Caused by an Injury and occurring within 365 days of the covered Accident		
	ACCIDENTAL DEATH	**$2,000**	
	DISMEMBERMENT		
	Loss of One Hand or One foot	**$1,000**	
	Loss of the Entire Sight of Both Eyes	**$1,000**	
	Loss of Both Hands or Feet	**$10,000**	

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.

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; (3) Injury sustained while violating or attempting to violate any duly enacted law; (4) Injury by acts of war, whether declared or not; (5) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (6) Injury covered by Worker's Compensation or the Occupational Disease Law; (7) 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; (8) Hernia, any type; (9) Injury sustained fighting or brawling, except in self-defense; (10) Suicide or attempted suicide; (11) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (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 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); (14) Injury sustained while participating in or practicing for senior high interscholastic tackle football including grade 9 if playing with grade 10 or above, including travel, unless optional coverage has been purchased; (15) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (16) Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay; (17) 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; (18) Dental treatment, except as specifically stated; (19) Services of an assistant surgeon or Doctor when surgery is performed; (20) Eyeglasses, contact lenses, routine eye exams or prescriptions therefore; (21) Prescription Drugs, crutches, braces, artificial limbs, etc., except as specifically stated.

Administered by: **STUDENT PROTECTIVE AGENCY,** 300 Coshocton Ave., Mount Vernon, OH 43050 • (800) 278-2544

Underwritten and claims paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL),** 1275 Milwaukee Ave., Glenview, IL 60025 • (800) 622-1993

2022-2023 School Year Enrollment Form

GTL | GUARANTEE TRUST LIFE

PLEASE PRINT CLEARLY

One Time Annual Payment		
OPTIONS	**Low Option**	**High Option**
24-Hour-A-Day Plan		
Students Grades K-6	❑ $79	❑ $158
Students Grades 7-12	❑ $91	❑ $182
School-Time Plan		
Students Grades K-6	❑ $23	❑ $46
Students Grades 7-12	❑ $37	❑ $74
Optional Football Coverage (Grades 10-12, including grade 9 if playing with 10-12) 2022 Season Only Per Player	❑ $129	❑ $258
TOTAL $_____ (Please do not send cash)		
Make check payable to your local agency		
No Refunds are available		

Student's Name _____
First Name Middle Initial Last Name

Date of Birth _____ **Male** ❑ **Female** ❑
Month Day Year

School District _____ **School** _____

Grade _____ **Student's Address** _____

City _____ **State** _____ **Zip** _____

Telephone # _____ **Date of Enrollment** _____

Parent or Guardian's Email Address _____

Name of Parent or Guardian (please print) _____

_____
Signature of Parent or Guardian

GA-15-KEF

PLEASE REMEMBER TO:

COMPLETE THE ENROLLMENT FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.

MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE ENROLLMENT FORM WITH YOUR CHECK OR MONEY ORDER TO:

STUDENT PROTECTIVE AGENCY
300 Coshocton Avenue
Mount Vernon, OH 43050

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

NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the Organization **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Group or Association name on the claim form. Also, the "Authorization To Permit Use and Disclosure of Health Information" must be signed.

- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your policy for the "Initial Treatment Period".

- PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED **WITHIN 90 DAYS OF THE ACCIDENT**. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED **WITHIN 90 DAYS OF TREATMENT**.

- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
  1) **The date(s) of treatment,**
  2) **The type(s) of service,**
  3) **The diagnosis,**
  4) **The medical provider's name and address**
  5) **The individual charge for each expense.**

- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement. **Please note**: This is not necessary if you have purchased a "Primary" plan through GTL that pays regardless of other insurance payments.

- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

GUARANTEE TRUST LIFE INSURANCE COMPANY
P.O. Box 1148
Glenview, Illinois 60025

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.

- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.

- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please take note that your claim will result in a processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at (800) 622-1993.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

GUARANTEE TRUST LIFE INS. CO.
P.O. Box 1148
Glenview, IL 60025
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: _____ Hosp.: _____ Other: _____
Addr: _____ Addr: _____ Addr: _____
_____ _____ _____
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE _____ **SIGNATURE OF PARENT OR GUARDIAN** _____
Claimant – if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. **Claimant's FULL NAME** _____ Alternate Name _____ Date of Birth ___/___/___ Grade _____

2. Claimant's Address: Street or RFD _____ City _____ State _____ Zip _____

3. Date of Accident _____ 20_____ Hour _____ AM ☐ PM ☐

4. Description of Accident: **(A)** How and where did in occur? _____
_____ (if more space needed, attach separate sheet)
(B) Nature of Injury _____

5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ Intramural ☐ Interscholastic ☐ Other ☐

6. **(A)** On date of accident what time did school start for this student? _____ AM ☐ PM ☐
(B) What time was student dismissed from school? _____ AM ☐ PM ☐

7. Has a previous claim been filed for this accident? Yes ☐ No ☐

8. **(A)** Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? Yes ☐ No ☐
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary ☐ Jr. High ☐ High ☐ Other ☐

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. DO YOU HAVE ANY OTHER INSURANCE WHICH WILL OR HAVE COVERED THE EXPENSES RELATED TO THE ABOVE ACCIDENT, SUCH AS GROUP, INDIVIDUAL, AUTOMOBILE MEDICAL, OR LIABILITY? ☐NO ☐YES
IF YES, PLEASE GIVE THE INSURANCE COMPANY'S NAME, PHONE NUMBER AND POLICY NUMBER:
Insurance Company Name: _____

Phone # _____ **Policy #** _____

10. Parents Name: Father _____ Mother _____
Employer's Name: _____ _____
Employer's Address. _____ _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: _____ SIGNATURE: _____
(Claimant, or Parent if Claimant is a minor)

Note: ***Your State Insurance Department requires us to notify you that:*** 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

_____
(Print Please) Name of Patient — Date of Birth

_____
Signature of Patient — Date

_____
(Please Print) Name of Authorized Representative, or Next of Kin

_____
Relationship of Authorized Representative or Next of Kin to Patient

_____
Signature of Authorized Representative or Next of Kin — Date