VOLUNTARY ACCIDENT INSURANCE FOR YOUR STUDENT

2023-2024
Parent Packet

- **Make sure your child is properly covered against unforeseen accidents.**
- **Purchase coverage at your convenience from any computer.**
- **Follow the easy step-by-step instructions and you're done in minutes!**

Contact Us

310-826-5688

SIRep@studentinsuranceusa.com

STUDENT INSURANCE
A VENBROOK COMPANY

Affordable & Easy

Student Accident Insurance

Parent/ Legal Guardian Information Flyer
Student Accident Insurance

STUDENT INSURANCE

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Supplemental student accident insurance is available for your child/children through **Student Insurance.**

"School Time Coverage" is in force for the hours and days when school is in session and while attending school sponsored and supervised activities on or off the school premises.

This plan does not cover Athletics/UIL activities in grades 7-12.

"24-Hour Coverage" is in force around the clock, 24 hours a day, including summer, weekends, and vacation periods. Protected at home or while away – any time, any place, anywhere. The UIL/Sports Coverage protects students while at practice or participating in school sponsored and supervised UIL Activities and Sports for grades 7-12.

Football Coverage for grades 9-12 is excluded.

"Football Coverage" is in force while students participate in practice or play of school sponsored and supervised football activities, including travel to and from by in-school transportation. This coverage is for grades 9-12. School time and 24 hour coverages must be purchased separately.

Student accident insurance plans offer ACCIDENT coverage and contain limitation and exclusions. Full plan brochures and online enrollment is available at www.studentinsuranceusa.com or if you do not have access to a computer you may contact us at 310-826-5688 or request a brochure from your school administrator.

El seguro de accidentes estudiantiles suplementarios está disponible para su hijo/a a través de **Student Insurance.**

"Cobertura de Tiempo Escolar" está en vigor por las horas y días en que la escuela está en sesión y mientras asiste a las actividades patrocinadas y supervisadas de la escuela dentro ofuera de las instalaciones de la escuela. **Este plan no cubre las actividades de atletismo/UIL en los grados 7-12.**

"Cobertura de 24 Horas" está en vigor todo el día, 24 horas al día, incluyendo el verano, fines de semana y períodos de vacaciones. Protegidos en el hogar o mientras lejos – en cualquier momento, y en cualquier lugar. La cobertura de deportes UIL protege a los estudiantes mientras que en la práctica o participando en actividades de UIL y deportes que son patrocinadas y supervisadas por la escuela para los grados 7-12. **La cobertura de fútbol para los grados 9-12 está excluida**

La **"Cobertura de Fútbol"** está vigente mientras los estudiantes participan en la práctica o el juego de actividades de fútbol patrocinadas y supervisadas por la escuela, incluidos los viajes de ida y vuelta en transporte escolar. Esta cobertura es para los grados 9-12. El tiempo escolar y las coberturas de 24 horas se deben comprar por separado.

Los planes de seguro del estudiante ACCIDENTES ofrecen cobertura de accidentes y contienen limitaciones y exclusiones. Folletos completos del plan y la inscripción en línea está disponible en www.studentinsuranceusa.com o si usted no tiene acceso a una computadora usted puede contactarnos en 310-826-5688 o solicitar un folleto de su administrador de la escuela.

Parent Letter

August 2023

Dear Parent or Guardian:

The school district does not provide any type of health or accident insurance for injuries incurred by your child at school or participating in school-related activities.

As a service to students and their families, the district makes available a student accident insurance plan for you to purchase for your child at a reasonable cost.

The coverages available and the premiums charged are listed below:

REASONS TO PURCHASE THIS COVERAGE:

This plan will provide benefits for medical expenses incurred because of an accident. If you have other insurance, benefits can be applied to your deductible or co-pays.

If you have no other insurance, this will become your primary accident plan.

PURCHASE COVERAGE ON-LINE (with Credit/Debit card) at
www.studentinsuranceusa.com

All questions regarding this coverage should be directed to Student Insurance at 310-826-5688 or 800-367-5830

STUDENT INSURANCE
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STUDENT INSURANCE

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STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.

Annual Premium: Plan "Low" – $14.00 Plan "Medium" – $28.00 Plan "High" – $43.00

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).

Annual Premium: Plan "Low" – $82.00 Plan "Medium" – $105.00 Plan "High" – $210.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.

Annual Premium: Plan "Low" – $85.00 Plan "Medium" – $115.00 Plan "High" – $215.00

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.

Annual Premium: $8.00

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted (no pro rata premiums available).

STUDENT INSURANCE
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Accidentes no deben suceder, pero a veces suceden.

Nosotros le ofrecemos cobertura durante recesos, paseos/ dias de campo, deportes y actividades diarias donde pueden ocurrir lesiones/accidentes. Contar con cobertura durante el horario escolar, o en todo momento, le asegura que sus seres queridos reciban el cuidado medico necesario sin crear problemas financieros. Todos los estudiantes inscritos en esculea publica, charter o privada son elegibles para obtener cobertura.

SEGURO ESCOLAR DE ACCIDENTES PARA ESTUDIANTES (K-12) DISPONIBLE A TRAVÉS DE SU ESCUELA:

- Accidentes en la Escuela
- Accidentes las 24 Horas al Día
- Deportes Interescolares
- Dental 24 Horas

Todos los planes disponibles son ofrecidos por Special Markets Insurance Consultants, Inc. Por favor visite nuestro servicio de inscripcion en línea en **www.studentinsuranceusa.com** para obtener mas información acerca de los planes que su escuela ofrece.

PAGO
La inscripción y el pago son responsabilidad de los padres y/o representantes del estudiante.

COMO INSCRIBIRSE

1. Vaya a Studentinsuranceusa.com haga click en **K-12 Student Insurance**
2. Eliga "**ENROLL NOW**"
3. Eliga su estado y su escuela
4. Eliga su plan de la lista de opciones
5. Llene la informacion de el estudiante y pago
6. Inprima su recibo

STUDENT INSURANCE
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Si tiene preguntas favor de llamar
310-826-5688

Sobre Student Insurance
Desde 1950 Student Insurance, Inc. (SI) ha ofrecido Seguro de Accidentes para Estudiantes de K-12. Por favor, visite www.studentinsuranceusa.com para obtener información adicional acerca de la cobertura de este plan, precios, beneficios.

2023-2024 STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.
Annual Premium: Plan "Low" – $14.00 Plan "Medium" – $28.00 Plan "High" – $43.00

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).
Annual Premium: Plan "Low" – $82.00 Plan "Medium" – $105.00 Plan "High" – $210.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.
Annual Premium: Plan "Low" – $85.00 Plan "Medium" – $115.00 Plan "High" – $215.00

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: $8.00**

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

SCHEDULE OF BENEFITS
Coverage for Injuries due to Accidents only

Maximum Benefit:	**Plan "Low"**	**Plan "Medium"**	**Plan "High"**
School-Time Option	$25,000	$50,000	$100,000
24-Hour Option	$25,000	$50,000	$100,000
Football Option	$25,000	$50,000	$100,000
Injuries Involving Motor Vehicles	$10,000	$10,000	$ 10,000
Death Benefit/Double Dismemberment	$10,000	$20,000	$ 20,000
Single Dismemberment	$ 5,000	$10,000	$ 10,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D/Loss of Sight Benefits	1 Year	1 Year	1 Year
Excess Coverage Applicability	Full Excess	Full Excess	Full Excess
Hospital/Facility Services - Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	65% RE*	75% RE*	80% RE*
Inpatient Hospital Miscellaneous	65% RE*	75% RE*	80% RE*
Hospital/Facility Services - Outpatient			
Free-Standing Ambulatory Surgical Facility	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Hospital Emergency Room	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Physician's Services			
Surgical	65% RE*	75% RE*	80% RE*
Assistant Surgeon	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	65% RE* / $25 Visit/5 Visit Max.	75% RE* / $30 Visit/7 Visit Max.	80% RE* / $40 Visit/8 Visit Max.
Physician's Non-surgical Treatment (Except as above)	65% RE*	75% RE*	80% RE*
Other Services			
Registered Nurses' Services	65% RE*	75% RE*	80% RE*
Prescriptions - outpatient	65% RE*	75% RE*	80% RE*
Laboratory Tests – Outpatient	65% RE*	75% RE*	80% RE*
X-rays, includes interpretation – Outpatient	65% RE*	75% RE*	80% RE*
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	65% RE*	75% RE*	80% RE*
Ground Ambulance	65% RE*	75% RE*	80% RE*
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	65% RE*	75% RE*	80% RE*
Dental Treatment to sound, natural teeth due to covered injury	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	$150 Maximum	$500 Maximum	$700 Maximum

***RE means Reasonable Expense**

GER_0418 EFTB(0009)

2023– 2024 ENROLLMENT APPLICATION (please print or type)

Student's Last Name _____ Student's First Name _____ Student's Middle Initial _____ Grade _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Birthdate _____

School System _____ Name of School _____

Check your selection:

Plan "Low"	q School-Time	$14.00	q 24-Hour Accident	$ 82.00	q Football	$ 85.00	q 24-Hour Dental	$8.00
Plan "Medium"	q School-Time	$28.00	q 24-Hour Accident	$105.00	q Football	$115.00	q 24-Hour Dental	$8.00
Plan "High"	q School-Time	$43.00	q 24-Hour Accident	$210.00	q Football	$215.00	q 24-Hour Dental	$8.00

Please make check payable to Gerber Life Insurance Company

Total Enclosed: _____

Signature of Parent or Guardian _____ Date _____

STUDENT INSURANCE

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Accidents aren't supposed to happen, but they do.

Coverage for School recess, one-day field trips, sports and general day-to-day activities because they can all lead to injuries. Having coverage during school hours, or around the clock 24 hours a day can insure your loved ones get the care they need without financial hardship to the family.

Any enrolled student is eligible for coverage.

K-12 ACCIDENT PLANS THAT ARE AVAILABLE THROUGH YOUR SCHOOL:

- School Time Accident Only
- 24-Hour Accident Only
- Interscholastic Sports
- 24-Hour Dental

All available plans are offered by Special Markets Insurance Consultants, Inc. To research which plans are being offered by your school, please visit our website's online enrollment tool at **www.studentinsuranceusa.com**

PAYMENT
Parents or guardians of students are responsible for enrollment and premium payment.

STEPS TO ENROLLING ONLINE

1. Go to Studentinsuranceusa.com at the top of the page click **K-12 Student Insurance** to see coverage options available to your students.
2. Click "**ENROLL NOW**" at the bottom of the page.
3. Click on your School District
4. Choose plan from the listed options
5. Complete student and payment information
6. **Print final page for your records**

STUDENT INSURANCE

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FOR QUESTIONS, PLEASE CALL
310-826-5688

About Student Insurance

Since 1950 Student Insurance, Inc. (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. For further details of the coverage outlined above, including costs, benefits, exclusions and any reductions or limitation, and the terms under which the policy may be continued in force, please refer to **www.studentinsuranceusa.com**. Students are able to purchase coverage only if his/her school district is a policyholder with the insurance company.

COBERTURA DE SEGURO DE ACCIDENTES PARA ESTUDIANTES 2023-2024

COBERTURA OPCIONAL DE ACCIDENTES DURANTE EL HORARIO ESCOLAR - Se proporciona cobertura de seguro por lesiones cubiertas que tienen lugar durante el horario y lo días en que la escuela está en funcionamiento y durante la asistencia o participación en actividades patrocinadas y supervisadas por la escuela tanto dentro como fuera de las instalaciones escolares. Incluye la participación en: Deportes intercolegiales, a excepción de fútbol americano intercolegial a nivel de escuela secundaria (consulte la Cobertura opcional para fútbol americano a continuación); actividades recreativas de verano patrocinadas por la escuela; excursiones escolares de un día de duración (sin pernoctación) y actividades religiosas patrocinadas por la escuela. Se proporciona cobertura para viajes hacia, desde o durante las actividades, como miembro de un grupo, en el transporte proporcionado u organizado por el titular de la póliza, y al viajar directamente de ida y vuelta entre sus casas y la escuela o el sitio de una actividad cubierta.

Prima anual: Plan "de bajo costo"–$14.00 Plan "de mediano costo"–$28.00 Plan "de alto costo"–$43.00

COBERTURA OPCIONAL POR ACCIDENTES DURANTE LAS 24 HORAS - La cobertura del seguro se proporciona durante las 24 horas del día. Proporciona cobertura durante los fine de semana y períodos de vacaciones, incluido todo el verano. Los estudiantes están protegidos mientras están en su casa o fuera de ella en cualquier entorno, en cualquier momento y en cualquier lugar. La cobertura se proporciona para la participación en deportes intercolegiales, a excepción de fútbol americano intercolegial a nivel de escuela secundaria (consulte la opción de Cobertura opcional para fútbol americano a continuación).

Prima anual: Plan "de bajo costo"–$82.00 Plan "de mediano costo"–$105.00 Plan "de alto costo"–$210.00

COBERTURA OPCIONAL PARA FÚTBOL AMERICANO - Cubre accidentes que ocurren durante la participación en la práctica o la competencia de fútbol americano intercolegial a nivel de escuela secundaria. Se cubre el viaje cuando se viaja directamente y sin interrupción hacia o desde tal práctica o competencia, como parte de un grupo, en el transporte proporcionado u organizado por el titular de la póliza. Consulte los beneficios y limitaciones que se describen en el interior de este folleto. La cobertura opcional para fútbol americano comienza en la fecha de la recepción de la prima y termina el último día de práctica o competencia. A los estudiantes de noveno grado que juegan SOLAMENTE con otros estudiantes de 9º grado, no se les cobra el adicional para la cobertura de fútbol americano. En caso de contratación, se aplicará su cobertura opcional durante el horario escolar o su cobertura opcional de accidentes las 24 horas.

Prima anual: Plan "de bajo costo"–$85.00 Plan "de mediano costo"–$115.00 Plan "de alto costo"–$215.00

COBERTURA DENTAL OPCIONAL DURANTE LAS 24 HORAS (puede adquirirse por separado o con otra cobertura) - La cobertura del seguro está en vigor las 24 horas del día. La lesión debe tratarse en un plazo de 60 días después de que ocurra el accidente. Los beneficios se pagan dentro de los 12 meses después de la fecha de la lesión. Los gastos máximos elegibles a pagar por lesión cubierta no pueden exceder los $ 25,000. Además, cuando el dentista certifica que el tratamiento debe aplazarse hasta después del período de beneficios, se pagarán beneficios diferidos hasta un máximo de $1000. El estudiante debe recibir tratamiento por lesión en los dientes, por parte de un dentista legamente calificado, que no sea miembro de la familia inmediata del estudiante. La cobertura se limita al tratamiento de dientes sanos y naturales. **Prima anual: $8.00**

PERÍODO DE COBERTURA - La cobertura en virtud de la cobertura opcional de accidentes durante el horario escolar, la cobertura opcional de accidente durante las 24 horas y la cobertura dental opcional durante las 24 horas comienza en la fecha de recepción de la prima, pero no antes del inicio del año escolar. La cobertura opcional de accidente durante el horario escolar termina al cierre del período regular escolar de nueve meses, excepto cuando el estudiante asiste a sesiones de clases patrocinadas, única y exclusivamente bajo la supervisión de la escuela durante el verano. La cobertura opcional de accidente durante las 24 horas y la cobertura dental opcional durante las 24 horas terminan cuando la escuela vuelve a abrir para el siguiente año escolar. La cobertura está disponible en virtud del plan durante el año escolar con las primas cotizadas **(no hay primas a prorrata disponibles)**.

PLAN DE BENEFICIOS

Cobertura de lesiones por accidentes únicamente

Beneficio máximo:	**Plan "de bajo costo"**	**Plan "de mediano costo"**	**Plan "de alto costo"**
Opción horario escolar	$25,000	$50,000	$100,000
Opción 24 horas	$25,000	$50,000	$100,000
Opción fútbol americano	$25,000	$50,000	$100,000
Lesiones que involucran vehículos de motor	$10,000	$10,000	$ 10,000
Beneficio por muerte/pérdida de dos miembros	$10,000	$20,000	$ 20,000
Pérdida de un miembro	$5000	$10,000	$10,000
Período de pérdida de los beneficios médicos	El tratamiento debe comenzar en un plazo de 60 días tras la fecha de la lesión		
Período de beneficios para beneficios médicos y AD&D/pérdida de la vista	1 año	1 año	1 año
Aplicabilidad de exceso de cobertura	Exceso total	Exceso total	Exceso total
Servicios hospitalarios/en instalaciones de salud - como paciente internado			
Ingreso y comidas en hospital (tarifa de sala semiprivada)	65% GR*	75% GR*	80% GR* Servicios
hospitalarios varios para pacientes internados	65% GR*	75% GR*	80% GR*
Servicios hospitalarios/en instalaciones de salud - como paciente ambulatorio			
Centro quirúrgico ambulatorio independiente	65% GR* a $500 como máximo	75% GR* a $800 como máximo	80% GR* a $1500 como máximo
Servicios hospitalarios varios para pacientes ambulatorios (a excepción de los servicios de médicos y radiografías que se pagan de la forma que se estipula a continuación)	65% GR* a $500 como máximo	75% GR* a $800 como máximo	80% GR* a $1500 como máximo
Sala de emergencia del hospital	65% GR* a $500 como máximo	75% GR* a $800 como máximo	80% GR* a $1500 como máximo
Servicios del médico			
Quirúrgicos	65% GR*	75% GR*	80% GR*
Asistente de cirujano	25% de los beneficios quirúrgicos	25% de los beneficios quirúrgicos	25% de los beneficios quirúrgicos
Anestesiólogo	25% de los beneficios quirúrgicos	25% de los beneficios quirúrgicos	25% de los beneficios quirúrgicos
Tratamiento ambulatorio del médico en relación con la fisioterapia y/o la manipulación espinal	65% GR*/$25 por visita/5 visitas como máximo	75% GR*/$30 por visita/7 visitas como máximo	80% GR*/$40 por visita/8 visitas como máximo
El tratamiento del médico no quirúrgico (con excepción de lo anterior)	65% GR*	75% GR*	80% GR*
Otros servicios			
Servicios de enfermeras profesionales tituladas	65% GR*	75% GR*	80% GR*
Recetas - paciente ambulatorio	65% GR*	75% GR*	80% GR*
Análisis de laboratorio - paciente ambulatorio	65% GR*	75% GR*	80% GR*
Radiografías, incluye la interpretación - paciente ambulatorio	65% GR*	75% GR*	80% GR*
Servicio de diagnóstico por imágenes (imágenes por resonancia magnética, tomografía axial computarizada, etc.) - incluye interpretación	65% GR	75% GR*	80% GR*
Ambulancia terrestre	65% GR*	75% GR*	80% GR*
Equipo médico duradero (incluye aparatos y dispositivos de asistencia ortopédicos)	65% GR*	75% GR*	80% GR*
Tratamiento dental para dientes sanos y naturales debido a una lesión incluida en la cobertura	65% GR* a $500 como máximo	75% GR* a $800 como máximo	80% GR* a $1500 como máximo
Reemplazo de anteojos, audífonos, lentes de contacto si también se recibe tratamiento médico para la lesión cubierta.	$150 como máximo	$500 como máximo	$700 como máximo

***GR significa Gastos razonables**

GER_0514 EFTB(0009)

SOLICITUD DE INSCRIPCIÓ 2023 - 2024 (complete en letra de imprenta o a máquina)

Apellidos del estudiante _____ Nombre del estudiante _____ Inicial seg. nombre del estudiante _____ Grado _____

Dirección _____ Ciudad _____ Estado _____ Código postal _____

Número de teléfono _____ Fecha de nacimiento _____

Sistema escolar _____ Nombre de la escuela _____

Marque su selección:

Plan "de bajo costo"	q Horario escolar	$14.00	q Accidente las 24 horas	$ 82.00	q Fútbol americano	$ 85.00	q Dental las 24 horas	$8.00
Plan "de mediano costo"	q Horario escolar	$28.00	q Accidente las 24 horas	$105.00	q Fútbol americano	$115.00	q Dental las 24 horas	$8.00
Plan "de alto costo"	q Horario escolar	$43.00	q Accidente las 24 horas	$210.00	q Fútbol americano	$215.00	q Dental las 24 horas	$8.00

Emita el cheque pagadero a nombre de Gerber Life Insurance Company

Total que se adjunta: _____

Firma del padre/madre o tutor _____ Fecha: _____

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

♦ Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦ If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

1) HCFA-1500 (standard form used by Providers; sample attached)
2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
3) ADA Dental Claim Form (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦ If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦ Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

♦ If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦ Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

Por favor, lea esta información cuidadosamente. Es importante.

SIGA ESTAS INSTRUCCIONES PARA PRESENTAR UNA RECLAMACIÓN

Toda la información debe ser proporcionada para que la reclamación sea procesada. PROCESAMIENTO DE SU RECLAMACIÓN SE RETRASARÁ SI NO SE RECIBE INFORMACIÓN COMPLETA

NOTA: Los beneficios de la póliza de accidentes son limitados y pueden no proporcionar cobertura del 100%. La cobertura de gastos médicos por accidente bajo esta póliza se proporciona en Exceso, y en la mayoría de los casos, los beneficios solo se pagarán bajo este plan después de que su propio seguro personal o de grupo haya pagado sus beneficios. Completar un formulario de reclamación no garantiza el pago de beneficios. Cada reclamación se examina de conformidad con las disposiciones de la política.

Directrices de reclamación: Se deben seguir las siguientes directrices.

♦Responda todas las preguntas en detalle (incluyendo todas las firmas en la parte delantera y trasera del formulario). Un formulario de reclamación debe ser completado para cada accidente.

♦Si tiene otro seguro, presente su reclamo a su otra aseguradora. Cuando reciba el aviso de explicación de beneficios (muestra adjunta) de su compañía principal, envíelo a nosotros junto con las facturas médicas correspondientes de HCFA/UB04 y con el formulario de reclamo completo. Debe presentar las facturas médicas del proveedor; Los estados de cuentas pendientes no serán procesados. Las facturas médicas deben incluir el procedimiento y el código de diagnóstico junto con el número de identificación federal del proveedor. Estos proyectos de ley son:

1) HCFA-1500 (formulario estándar utilizado por los proveedores; muestra adjunta)
2) UB-04 o UB-92 (formulario estándar utilizado por la muestra de hospitales adjunta)
3) ADA Dental Claim Form y una carta del dentista verificando que el diente lesionado estaba completo, sano y natural. (Todas las facturas dentales deben ser enviadas a través de los planes médicos y dentales de su seguro primario primero antes de enviar las facturas a WebTPA)

Sería útil que se diera lo siguiente a todos los proveedores a los que la persona lesionada está buscando tratamiento:

1. Información de contacto de WebTPA
2. Nombre de organización/escuela encontrado en el formulario de reclamación
3. Número de póliza encontrado en el formulario de reclamación

De esta manera, los proveedores de servicios pueden trabajar directamente con la oficina de reclamos y proporcionarles los formularios de facturación correctos (factura detallada para incluir el procedimiento y el código de diagnóstico y el número de identificación fiscal) necesarios para procesar una reclamación.

♦Si ya pagó la factura médica, incluya un recibo pagado o una copia de su cheque cancelado al mismo tiempo que presenta la factura médica. De lo contrario, el pago se hará a los proveedores de servicios (Hospital, Médico u otros).

♦Enviar toda la correspondencia a WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099- 2415**. El formulario de reclamo debe ser enviado dentro de los 90 días de la fecha en que recibió atención médica por primera vez. Cualquier factura no presentada con el formulario de reclamo debe ser enviada, dentro de los 90 días de la fecha en que recibió atención médica, a la Compañía identificada con el nombre del reclamante, el nombre de la Organización o Escuela y la fecha del Accidente. Presente la reclamación electrónicamente haciendo clic aquí.

♦Si cambia su dirección, por favor notifique a WebTPA, Inc. enviando una notificación a WebTPA para que no haya demora en el procesamiento de cualquier reclamo.

♦Póngase en contacto con WebTPA, Inc. llamando al 866-975-9468si desea verificar el estado de su reclamo o si tiene alguna pregunta sobre cómo se procesó su reclamo o el beneficio pagado.

Causas comunes de retrasos en la tramitación de reclamaciones

1. Formularios de reclamación no completados en su totalidad o no presentados.
2. Saldo adeudado, saldo a plazo o estados vencidos presentados para facturas.
3. Explicación de los Beneficios de la Aerolínea Primaria No Proporcionada con las Facturas.

Guarde copias de todos los formularios de reclamo, facturas médicas y correspondencia para sus propios registros hasta que su reclamo haya sido procesado.

Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. **PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2**
2. **ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE**
3. **SEND ALL CORRESPONDENCE TO:**

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com

IMPORTANT NOTICE:
Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

⮜ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED ⮞

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name _____ Policy Number _____

School/Team/League Name _____ Phone No. ( )_____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other _____

Name of injured person/student _____

Date of Accident _____ Accident Time _____

Date of First Treatment _____Has treatment been completed? ☐Yes ☐No

Where and how did accident occur? (Please be specific) _____

_____

_____

_____

Part of body Injured _____ ☐Right or ☐Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? _____ Was he/she a witness? ☐Yes ☐No

Authorized Signature _____ Title Exec. Director, Risk Mgt. & Captive Insurance Date _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name _____ Preferred/Nickname:_____

Date of Birth _____ Age _____ Grade Level _____ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Child Care ☐Participant ☐CE Student (# of credits____)

Address of Injured Person or Parents/Guardian _____

_____

Phone No. ( )_____ Email Address _____

If Injured party is over age 18: Employer Name and Address _____

_____

Phone No. ( )_____ ☐Self Employed ☐Unemployed

Father/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	**Address**	**Policy #**

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No **(See IMPORTANT NOTICE at top of form on page 1)**

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party _____

_____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian _____ Date: _____

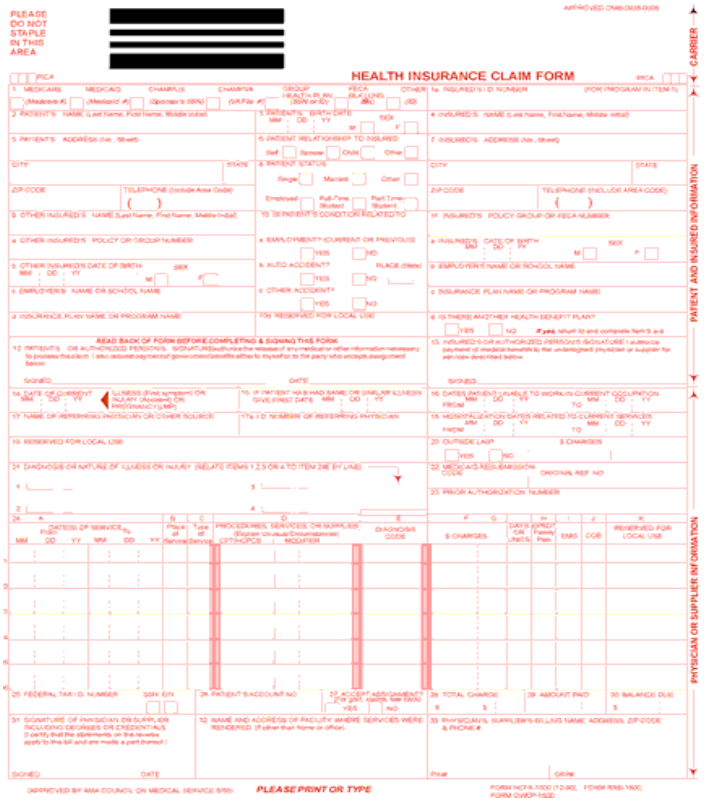
SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian _____ Date: _____

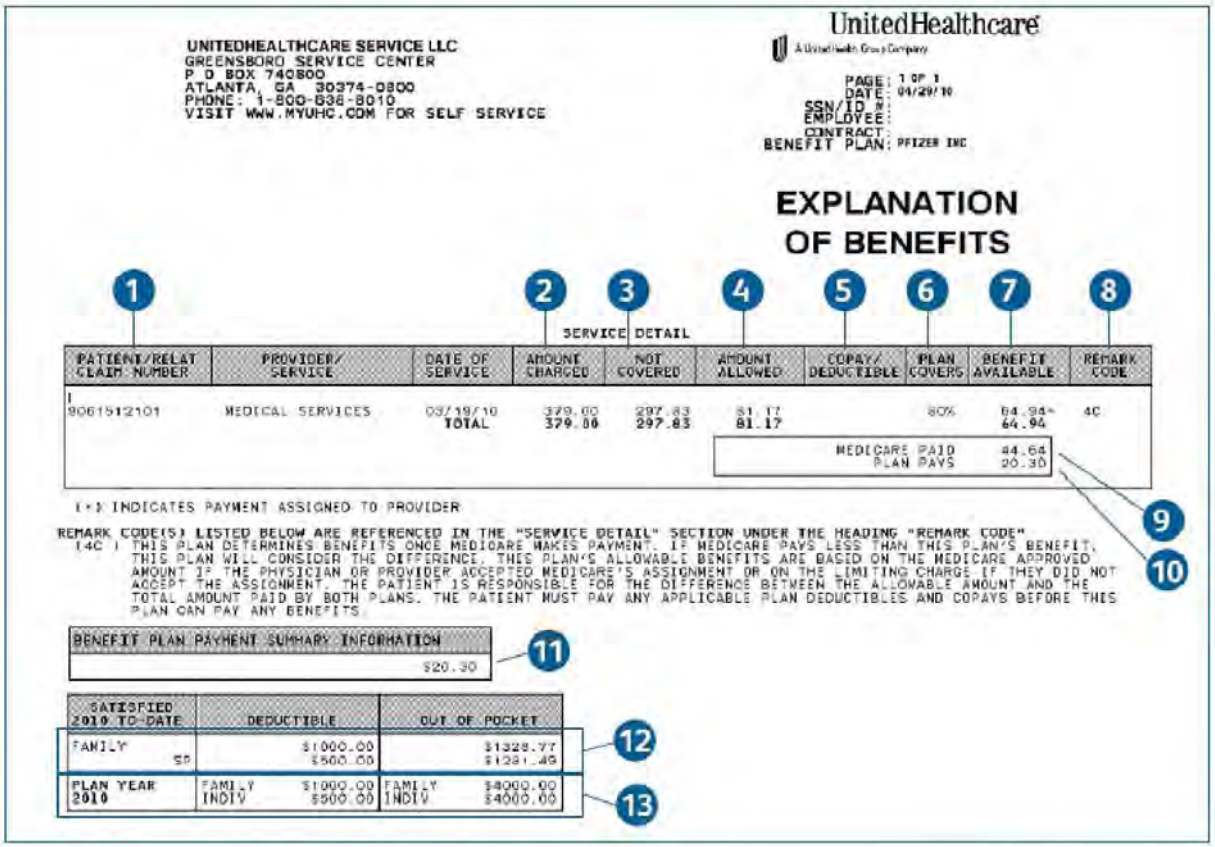
SAMPLE HCFA 1500



HEALTH INSURANCE CLAIM FORM

SAMPLE UB-04

SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	2 DATE OF SERVICE	3 AMOUNT CHARGED	NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94^	4C
	TOTAL		379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(^) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE		OUT OF POCKET	
FAMILY	$1000.00		$1328.77	
SP	$500.00		$1281.46	
PLAN YEAR 2010	FAMILY	$1000.00	FAMILY	$4000.00
	INDIV	$500.00	INDIV	$4000.00