NEW JERSEY VOLUNTARY STUDENT ACCIDENT - PREMIER AND ECONOMY PLANS

AT SCHOOL COVERAGE **Premier $ 30 Economy $ 20**

Voluntary Grades PK-12

(a) while on the School premises: during the hours and on the days School is in regular session, and during the hours and on the days when School is not in session while the Insured Person is participating in or attending any Sponsored and Supervised School Activity, except interscholastic high school football for students in the 10th grade or above (Senior High School) and Freshman Football (grade 9) if they practice or play with Senior High School; and

(b) while away from the School premises: other than traveling, if participating in a Sponsored and Supervised School Activity, except interscholastic high school football for students in the 10th grade or above (Senior High School) and Freshman Football (grade 9) if they practice or play with Senior High School; and

(c) while traveling directly to or from the Insured Person's residence and School: for regular School sessions, or for any Sponsored and Supervised School Activity in School designated vehicle, except interscholastic high school football for students in the 10th grade or above (Senior High School) and Freshman Football (grade 9) if they practice or play with Senior High School.

24 HOUR COVERAGE **Premier $ 98 Economy $ 64)**

Voluntary Grades PK-12

Coverage is in force for each person for whom the 24-Hour Coverage premium has been paid as set forth in the Policy on a twenty-four (24) hour per day basis, except for interscholastic high school football for students in the 10th grade or above (Senior High School) and Freshman Football (grade 9) if they practice or play with Senior High School.

EXCESS FOOTBALL COVERAGE 10-12 **Premier $ 235 Economy $ 187**
EXCESS FRESHMAN FOOTBALL (grade 9) **Premier $ 118 Economy $ 75**

Grades 10-12 and Freshman Football (grade 9) if they practice or play with Grades 10-12 (Maximum $25,000)

(a) while practicing for or competing in football which is a Supervised and Sponsored Sports Activity under the supervision of the Subscriber; and

(b) while traveling directly to or from such practice or competition in School designated vehicle.

MEDICAL PAYMENTS

The policy provides benefits for loss due to a Covered Injury up to the Total Maximum for all Accident Medical Benefits for each Covered Accident. Medical treatment must be provided by a qualified, licensed physician and must begin within 90 days from the date of the Covered Accident. Benefits will be payable for Covered Medical Expenses incurred within 730 days from the date of the Covered Accident (for Football within 365 days) up to the maximum Benefit Amount per service as shown on the Schedule of Benefits of the Policy.

Accidental Death & Dismemberment Benefits (Within 180 Days)

Loss of Life	$ 2,000
Loss of Two or More Hands or Feet or Loss of Sight of Both Eyes	$10,000
Loss of One Hand or Foot and Sight in One Eye	$10,000
Loss of One Hand and Foot	$10,000
Loss of Sight in One Eye or Loss of One Hand or Foot	$ 5,000
Loss Thumb and Index Finger of Either Hand	$ 500
Exposure and Disappearance	**Included**

Schedule of Benefits for Voluntary Student Accident Plans

	PREMIER PLAN	ECONOMY PLAN
COVERED EXPENSES	Maximum $500,000 Football Maximum $25,000	Maximum $25,000
In-Patient Hospital Services	Semi-private daily room rate up to $500/day;	the semi-private daily room rate
Hospital Miscellaneous Expenses	100% of URC Charges up to $3,000 per Covered Injury	100% of URC Charges up to $250 per day subject to a Maximum of $4,000 per Hospital Stay
Nurse Services	URC	100% of URC Charges up to $400 per Covered Injury
Orthopedic Appliances Outpatient	Paid under Medical Equipment	100% of URC up to $300 per Covered Injury
Emergency Room Treatment	100% of URC Charges up to $350 per Covered Injury	100% of URC Charges up to $75 per Covered Injury
Physician Services Surgery	100% of URC up to $5,000 per Covered Injury	75 % Usual and Customary Charges up to $3,500 Maximum
Assistant Surgeon	30% of Surgeon's allowance	25% of Surgeon's allowance
Use of Phy's Surgical Facilities	100% of URC Charges up to $2,000 per Covered Injury	100% of URC Charges up to $750 per Covered Injury
Anesthesia and its Administration	30% of Surgeon's allowance	25% of Surgeon's allowance
In-Hospital Visits	100% of URC Charges up to $55 first visit, $35 thereafter	100% of URC Charges up to $20 per visit (limited to one visit per day)
Office Visits	100% of URC Charges up to $55 first visit, $35thereafter	100% of URC Charges up to $20 per visit (limited to one visit per day)
Second Opinion or Consultation	100% of URC Charges up to $125 per Covered Injury	
Out Patient X-Ray	100% of URC Charges up to $400 per Covered Injury	100% of URC Charges up to $100 per Covered Injury
Out Patient CT Scan, MRI	100% of URC Charges up to $500 per Covered Injury	100% of URC Charges up to $250 per Covered Injury
Out Patient Laboratory Tests	100% of Usual and Customary Charges up to $175 per Covered Injury	100% of Usual and Customary Charges up to $25 per Covered Injury
Out Patient Physiotherapy	100% of URC Charges up to $50 per day, up to Maximum of $250	100% of URC Charges up to $20 per day up to a maximum of $40 (limited to one visit per day)
Ambulance Services	100% of URC Charges up to $800 per Covered Injury (first trip to Hospital only)	100% of URC Charges up to $100 Maximum (first trip to the Hospital only)
Medical Equipment *(Post surgical only)*	100% of URC Charges up to $500 per Covered Injury	100% of URC Charges up to $150 per Covered Injury
Dental Services	100% of URC Charges up to $500 per tooth	100% of URC Charges up to $150 per tooth
Motor Vehicle Injury	No Benefits	Up to $5,000 per Covered Injury
Prescription Drugs (Out Patient)	100% of URC Charges up to $200 per Covered Injury	100% of URC Charges
Eyeglasses, Contact Lenses Hearing Aids	100% of URC Charges up to $200 per Covered Injury	100% of URC Charges

Coverage ends on the earliest of when the person is no longer eligible or the Policy Termination Date

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ENROLL ONLINE FOR QUICKER SERVICE www.mmc-ins.com or COMPLETE AND MAIL

⇨ _____ ____ _____ ___/___/_____
Student's First Name M Last Name Birth Date

⇨ _____ _____-_____-_____
Address City ST Zip Phone

⇨ _____ _____ _____
Name of School District (Required) Name of School Grade

Coverage Options	At School	24-Hour	Football (Grades 10-12)	Football (Grade 9)
Premier Plan	☐ $30.00	☐ $98.00	☐ $235.00	☐ $118.00
Economy Plan	☐ $20.00	☐ $64.00	☐ $187.00	☐ $ 75.00

Complete for ☐ MASTERCARD ☐ VISA Name on Card, Last _____ First _____

Card Number _____ Expiration Date Mo _____ Year _____

Cardholder Signature _____ Date _____

Voluntary Student Accident Insurance Plans - Exclusions

Benefits will not be paid for a Covered Person's loss which:

1. Is caused by or results from the Covered Person's own:
   a) Intentionally self-inflicted Injury, suicide or any attempt thereat. (In Missouri this applies only while sane.);
   b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);
   c) Commission or attempt to commit a felony;
   d) Participation in a riot or insurrection;
   e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
   f) Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;
2. Is caused by or results from:
   a. Declared or undeclared war or act of war;
   b. An Accident which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.);
   c. Aviation, except as specifically provided in this Certificate;
   d. Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.
   e. Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
      i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
      ii) The Covered Person was within a 25-mile radius of the site of the release either:
      1) At the time of the release; or 2) Within 24 hours of the start of the release.

Additional Exclusions

Benefits will not be paid for:

1. Normal health checkups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
   (a) Employed or retained by the Certificateholder; or
   (b) Who is the Covered Person or a member of his immediate family;
4. Charges which:
   (a) The Covered Person would not have to pay if he did not have insurance; or
   (b) Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   (a) An aircraft, except as a fare-paying passenger; (b) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or (c) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon: (a) A snowmobile; (b) Any two or three wheeled motor vehicle; (c) Any off- road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
   (a) The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
   (b) Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food, unless a Sickness Expense Rider is inforce under this Certificate;
11. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;
12. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Certificate;
13. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
14. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
15. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
16. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
17. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
18. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
19. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
20. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
21. Any loss which is covered by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
22. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
23. Rest cures or custodial care;
24. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
25. Expenses incurred for an Accident or Sickness after the Benefit Period shown in the Schedule of Benefits;
26. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;
27. Services and supplies furnished by the Policyholder's infirmary, its employees, or doctors who work for the Policyholder;
28. Any bacterial infection that was not caused by an Accidental cut or wound.

How to File a Claim

1. The claim form with filing instructions can be obtained by your school or from our website.
2. The claim form should be fully completed and submitted within 90 days of the accident.
3. Advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills. However, if you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to the address shown below.
4. Bills should include the date of service, name, mailing address, and phone number of the doctor/hospital, and the specific itemized charges (description of treatment and amount) incurred (including CPT/procedure codes). Incomplete information will delay claim review.
5. Only one claim form per accident needs to be submitted. Once completed, make a photocopy for your records, and mail to:

WebTPA: P.O. Box 669
Grapevine, TX 76099-0669

Student Insurance ID Card

Underwritten by United States Fire Ins. Co.

Student Name: _____

Accident Only Policy Selected: ☐ Premier Plan ☐ Economy Plan

Coverage Level Selected: ☐ At School ☐ 24-Hour ☐ Football 10-12 ☐ Football 9

Customer Service: 1-877-563-7492

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Enrollment Options

Option 1: Enroll online at mmc-ins.com

Option 2: Complete and detach the enrollment form and follow instructions below:

- Make Checks or money order payable to Monarch Management Corp. Do Not Send Cash. Credit card payment is also accepted.
- Clearly print name of child on the check or money order.
- Send the enrollment form and payment to:
  Monarch Management Corporation
  3201 Cherry Ridge Drive; Suite D405;
  San Antonio, TX 78230
- Your cancelled check, money order stub or credit card statement is your proof of purchase.
- Keep this for your reference, you will receive no policy.
- If you have questions about this coverage, please call Monarch Management Corp., 1-800-662-2778.

Underwritten by:

United States Fire Insurance Company

Offered by:

Monarch Management Corporation

Enroll online at www.mmc-ins.com

CRUM & FORSTER

WebTPA
An Aon Affinity Group Company

How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

WebTPA
P.O. Box 669
Grapevine, TX 76099-0669
Customer Service: (877) 563-7492
Fax: (469) 417-1989
Email: helpme@webtpa.com

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

The Participating Organization (not the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

HOW TO FILE A CLAIM

All information must be provided for a claim to be processed.

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer all questions and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to address below:
   WebTPA
   P.O. Box 669
   Grapevine, Texas 76099-0669
   Customer Service: 877-563-7492
   Fax: 469-417-1989
4. Advise all doctors / hospitals of this coverage so they may forward their itemized bills.
5. If you have already been to doctor / hospital and did not know about this coverage, send all itemized bills to address above.
6. Itemized bills should include name of doctor / hospital, complete mailing address, telephone number, date seen, what you were seen for (diagnosis) and specific itemized charges incurred. (Description of treatment including CPT codes and amount).
7. If you have other insurance, submit a claim to your other insurer. When an Explanation of Benefits is received from Primary Carrier, mail to address above along with all corresponding itemized bills and completed claim form. You must submit itemized bills which include:
   a) HCFA-1500 (standard form used by Providers)
   b) UB-04 or UB-92 (standard form used by Hospitals)
8. If you already paid the bill, include a paid receipt or copy of your cancelled check. Payment will be made to the Provider of Service unless a paid receipt statement accompanies the bill when claim form is submitted.
9. **Common Causes For Delays in Processing Claims**
   a) Claim Form not fully completed or not submitted.
   b) Balance Due, Balance Forward or Past Due statements submitted as itemized bills.
   c) Explanation of Benefits from Primary Carrier not provided with itemized bills.

Keep Copies of All Correspondence For Your Own Records Until Claim Has Been Processed.

CRUM & FORSTER

WebTPA

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Policyholder / Organization Name:		Event, Activity or Sport:	
Name of School:	Street Address	City	State	Zip Code
Claimant's Name (Injured Person)	Social Security Number	Gender ☐M ☐F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a: ☐ Participant ☐ Staff Member ☐ Other
Dental Claims: Indicate which Teeth were Involved in the Accident		Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) | Did Injury Result in Death? ☐YES ☐NO

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐YES ☐NO
B. On activity premises? ☐YES ☐NO
C. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
D. During a participating organization practice? ☐YES ☐NO or competition? ☐YES ☐NO

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐YES ☐NO

If Yes, name of insurance company::_____ Policy #:_____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐YES ☐NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ DATE _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **United States Fire Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***United States Fire Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fins and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the 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 may have violated state law.