

# STUDENT ACCIDENT INSURANCE



## Parents & Guardians

- Does your child have adequate insurance?
- Do you have a deductible or co-pay with your current coverage?
- Multiple Coverage Options and Rates

**Dental Accident Plan Up to \$5,000 for \$8**  
See Details Inside



**STUDENT ASSURANCE SERVICES INCORPORATED**

1-800-328-2739

www.sas-mn.com

GHA-2203(GEN)

X \_\_\_\_\_  
(Signature of Parent or Guardian) (Date)

Students D.O.B. \_\_\_\_\_  
Grade \_\_\_\_\_  
Phone \_\_\_\_\_

Name of District \_\_\_\_\_  
Name of School \_\_\_\_\_  
Email Address \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip)

STUDENT'S FIRST NAME \_\_\_\_\_  
Please Print  
Address \_\_\_\_\_  
(Street)  
M.I. \_\_\_\_\_  
STUDENT'S LAST NAME \_\_\_\_\_  
(one letter in each box)



### ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE

DATE RECEIVED BY SCHOOL \_\_\_\_\_  
(Must be dated by a school official)

A-1511(2015)

Make Checks payable to: **STUDENT ASSURANCE SERVICES, INC.**  
\*Please write student's name on the front of check. NO REFUNDS

DO NOT SEND CASH TOTAL PREMIUM

COVERAGE PLANS	One Time Annual Premiums
<input type="checkbox"/> \$ 89 Full Time Coverage (Does NOT include Interscholastic Sports Coverage)	
<input type="checkbox"/> \$154 Full Time Coverage (Includes All Interscholastic Sports Coverage Except Football Grades 9-12)	
<input type="checkbox"/> \$ 14 School Time Coverage (Does NOT include Interscholastic Sports Coverage)	
<input type="checkbox"/> \$ 79 School Time Coverage (Includes All Interscholastic Sports Coverage Except Football Grades 9-12)	
<input type="checkbox"/> \$185 Football Coverage (Grades 9-12)	
<input type="checkbox"/> \$ 8 Extended Dental Coverage	

### STUDENT ACCIDENT INSURANCE CREDIT CARD PAYMENT FORM

INDICATE PREMIUM SELECTED AND COMPLETE THE REQUESTED ENROLLMENT INFORMATION FOUND ON THE REVERSE SIDE OF THIS FORM.  
There is a \$5.00 Processing Fee added to ALL Credit Card Transactions (does not apply to IN residents)

Please charge \$ \_\_\_\_\_ + \$5.00 Processing Fee = \$ \_\_\_\_\_ to the following credit card:  VISA®,  MasterCard®, or  Discover®

Credit Card Number \_\_\_\_\_  
Security Code (on back of card, 3 digits) \_\_\_\_\_  
Card Expiration Date (Month) (Year) \_\_\_\_\_  
Card Expiration Date \_\_\_\_\_  
Print Cardholder Name \_\_\_\_\_  
Date \_\_\_\_\_  
Cardholder Signature \_\_\_\_\_  
Cardholder Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
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**DETACH - Place inside envelope**

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## WHY SHOULD MY STUDENT BE COVERED BY THIS INSURANCE?

As a service to its students, your school is offering an opportunity to enroll in a student accident insurance plan administered by Student Assurance Services, Inc. Participation in this plan is voluntary. This brochure describes several coverage and premium options. Please review the entire brochure before making a decision to purchase this insurance or contact us directly with your questions.

## WHY IS THE SCHOOL PARTICIPATING IN THIS OFFERING?

Students are particularly susceptible to accidental injury. Your school does not carry medical insurance to pay for x-rays, stitches, ambulances, or other medical expenses.

## WHAT KIND OF INSURANCE IS THIS?

This is supplemental accidental bodily injury insurance; it covers accidental bodily injury occurring while the coverage is in force. Medical illnesses such as ear infections or sore throats are not covered.

## WHO SHOULD CONSIDER BUYING THIS INSURANCE?

1. All families with no other health coverage.
2. Families with other health coverage having deductibles, copays, or coinsurance. Our policy applies benefits toward your other health coverage out-of-pocket expenses. There is no deductible or copay in our policy.

## WHEN AND HOW CAN I ENROLL?

You can purchase this insurance anytime between the master policy effective date and expiration dates during the current school year. It is to your advantage to enroll early. The premium cannot be prorated. Make check payable to: Student Assurance Services or fill out the credit card information, and enclose in the attached envelope. Write the student's name on the check. Save this brochure for your records, you will not receive a master policy or ID card!

## EXCLUSIONS (What the Plan DOES NOT Pay)

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are paid under Worker' Compensation or Employer's Liability Laws.
3. Any injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Replacement of contact lenses, eyeglasses, hearing aids or prescriptions or examinations thereof.
5. The practice or play of interscholastic sports including travel to or from such activity, practice, or play for students in the 7th grade or above, unless such premium is paid.

## WHAT ARE THE EFFECTIVE AND EXPIRATION DATE OF COVERAGE?

Coverage becomes effective the later of: the Master Policy effective date; or 12:01AM following the date the envelope containing the enrollment form and premium is received and dated by the School, the Company or its authorized agent. Interscholastic sports coverage will expire on the last day of the authorized season of the current school year. School-Time and Full-Time Coverages end the first day of school next year.

## HOW DO I FILE A CLAIM?

1. Notify the school and obtain a claim form immediately. They will fill out Part A if it's a school injury.
2. Parents complete Part B. **Answer all questions.**
3. Submit copies of your *itemized bills* to your own family medical and dental coverage first, even if you have a large deductible. You will be sent a report called an Explanation of Benefits (EOB). This plan is supplemental to all other valid coverage. You must file a claim with your other coverage first! This Plan **DOES NOT** cover penalties imposed for failure to use providers preferred or designated by your primary coverage.
4. Send our claim form, copies of itemized bills and the EOB to:  
**STUDENT ASSURANCE SERVICES, INC.**  
PO BOX 196 • STILLWATER, MN 55082
5. No claim can be completed until **all of the above documents** have been provided.

**NOTE:** Student must be treated by a Licensed Physician within 60 days of the date of the injury. Proof of claim should be submitted within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills should be submitted within 90 days from the date of treatment or reasonable time thereafter not to exceed one year. We are responsible only for expenses incurred within one year.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Accident Insurance Policy Form GH-2200 (and any state specific), and any applicable endorsement(s); Extended Dental Coverage GHE-2201 (and any state specific). This policy is considered term accident insurance and is non-renewable. This product may not be available in all states and is subject to individual state regulations. The Master Policy is issued to the School District/School. A copy of the Privacy Notice may be obtained on the website [www.sas-mn.com](http://www.sas-mn.com).

Administered by  
**STUDENT ASSURANCE SERVICES, INC.**  
PO BOX 196, STILLWATER, MN 55082  
(800) 328-2739 - (651) 439-7098

Underwritten by  
  
**SECURITY LIFE**  
INSURANCE COMPANY OF AMERICA  
MINNETONKA, MINNESOTA

**HAVE QUESTIONS?  
CALL US TOLL FREE AT  
(800) 328-2739 OR (651) 439-7098  
OR [www.sas-mn.com](http://www.sas-mn.com)**

**THE POLICY CONTAINS A PROVISION LIMITING COVERAGE TO USUAL AND CUSTOMARY CHARGES. THIS LIMITATION MAY RESULT IN ADDITIONAL OUT-OF-POCKET EXPENSES FOR THE INSURED.**

# Premium & Coverage Options

POLICY FORMS GH-2200 (MN)

One Time Annual Premiums



**Full Time Coverage Grades PK-12**  
(Does NOT include Interscholastic Sports Coverage)

**\$89**

Covers the student 24 hours a day until school starts next year. Includes coverage while at home, at school, weekends and summer vacation. DOES NOT cover participation in interscholastic sports for students in grades 7-12.



**Full Time Coverage Grades PK-12**  
(Includes All Interscholastic Sports Coverage Except Football Grades 9 - 12)

**\$154**

In addition to the Full-Time Coverage shown above, the All Interscholastic Sports Coverage protects the student while practicing or participating in school-sponsored and school-supervised interscholastic sports including travel in school-provided transportation for grades 7-12. It DOES NOT cover Football for grades 9-12.



**School Time Coverage Grades PK-12**  
(Does NOT include Interscholastic Sports Coverage)

**\$14**

Protects the student while: a) attending regular school sessions, b) participating in or attending school-sponsored and supervised extra-curricular activities, c) traveling directly to and from school for regular school sessions and while traveling to and from school-sponsored and supervised activities in school provided transportation, DOES NOT cover participation in interscholastic sports for students in grades 7-12. Coverage ends the first day of school next year.



**School Time Coverage Grades PK-12**  
(Includes All Interscholastic Sports Coverage Except Football Grades 9 - 12)

**\$79**

In addition to School-Time Coverage shown above, the All Interscholastic Sports Coverage protects the student while practicing for or participating in school-sponsored and supervised interscholastic sports including travel in school provided transportation, for grades 7-12. It DOES NOT cover Football for grades 9-12.



**Football Coverage Grades 9-12**

**\$185**

Protects the student while practicing for or participating in school-sponsored and school-supervised interscholastic football including travel in school-provided transportation.



**Extended Dental Coverage**  
Grades PK-12

**\$8**

Provides benefits up to a maximum of \$5,000 for any dental injury. Covers the student 24 hours a day until school starts next year. Treatment must begin within 60 days from the date of the injury and must be performed within one year from the date of injury. However, if within the one year period following the date of injury the student's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the policy pays the estimated cost of such deferred treatment, but not to exceed \$200 for each tooth. Benefits for prosthetics are limited to \$500 per injury, including procedures performed to install them. Dental prosthetics includes, but is not limited to: crowns, dentures, bridges, and implants. Extended Dental does not cover treatment for orthodontics, dental disease, or expenses that exceed the dental prosthesis maximum benefit limit.

The Medical Benefits and Exclusions apply to the Coverage Options listed above.

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## Medical Benefits (What the plan pays)

When injury covered by this policy results in treatment by a Licensed Physician within 60 days from the date of accident, the Company will pay the Usual and Customary Charges (U&C) incurred for necessary Services and Supplies as listed below, for charges actually incurred within one year from the date of injury up to the specified Maximum Medical Benefit of \$50,000 per injury. Unless otherwise stated all amounts listed below are per injury. This policy will pay benefits regardless of Other Valid Coverage if the covered claim expense is less than \$200. If the covered claim expense exceeds \$200, benefits shall be paid first by Other Valid Coverage.

### PHYSICIAN'S SERVICES

- a) **Surgical Operations** (surgeon, assistant surgeon, and anesthesia)..... 80% U&C, up to \$1,500
- b) **Nonsurgical Care** (including physiotherapy treatment performed other than in a hospital, 1 treatment per day)..... U&C, up to \$50 for each treatment, maximum 6 treatments

### HOSPITAL CARE

- a) **Inpatient Care**
  - (1) **Hospital Semi-Private Room**..... U&C, up to \$500 per day
  - (2) **Hospital Miscellaneous** ..... 80% U&C, up to \$1,000

- b) **Outpatient Care** (facility charges for outpatient day surgery)..... U&C, up to \$1,000

- c) **Emergency Room**..... 80% U&C for hospital miscellaneous charges incurred, up to \$500

**Note: Benefits for miscellaneous charges are limited to services not scheduled under Medical Benefits.**

### X-RAY SERVICES

(includes charges for reading)..... U&C, up to \$200

**DIAGNOSTIC IMAGING** (includes MRI, CT scan, bone scan and charges for reading)..... U&C, up to \$500

**DENTAL TREATMENT** ..... U&C, up to \$200 for repair and/or replacement of each sound and natural tooth (in lieu of all other medical benefits)

**AMBULANCE SERVICES**..... U&C, up to \$500

**ORTHOPEDIC APPLIANCES** (when prescribed by a physician for healing)..... U&C, up to \$200

**PRESCRIPTION DRUGS** (take home)..... U&C, up to \$100

**MOTOR VEHICLE INJURY** ..... Same as any injury, up to \$1,000

### ACCIDENTAL DEATH AND DISMEMBERMENT

When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable.

Loss of Life.....	\$2,000	Double Dismemberment.....	\$10,000
Loss of an Eye.....	\$2,000	Single Dismemberment.....	\$ 2,000

IT IS NOT THE INTENT OF THIS POLICY TO PROVIDE BENEFITS FOR AN EXISTING MEDICAL PROBLEM. A re-injury will be covered if the insured has been treatment free for a period of 180 days prior to the effective date of the policy.