



Chartis  
Two Aquarium Drive  
Suite 200  
Camden, NJ 08103  
800 220 1123 Telephone



**PROPOSED FORM NUMBERS**

<b>FORM NO.</b>	<b>DESCRIPTION</b>
C11716DBG	Subrogation and Right of Recovery Endorsement
S30433DBG	Payment of Claims Amendatory Endorsement
S30549DBG-TX	Accident Medical Expense Benefit Rider
53593DBG	Texas Notice
89644 (7/05)	Coverage Territory Endorsement

**\*\*\*The Policy contains reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the policy. The policy shall govern in all cases.\*\*\***

BSR-TX

**Underwritten By: National Union Fire Insurance Company of Pittsburgh, Pa.  
ADDENDUM**

<b>Name of Policyholder:</b>		Hidalgo County	
100 E. Cano	Edinburg	TX	78539
Address	City	State	Zip Code

PLAN:  PRIMARY EXCESS OVER \$ \_\_\_\_\_  FULL EXCESS  PRIMARY

Accident Medical Expense:	Accidental Death Benefit:	\$5,000
Maximum Benefit Amount (per injury):	Accidental Dismemberment Benefit:	
Deductible Amount (per injury):	Principal Sum:	\$10,000
Benefit Period:	1 _____ Years	

(This space for Administrative Use Only)

Effective Date: 6/5/12 Reference Number: \_\_\_\_\_

Termination Date: 6/5/13 Policy Number: \_\_\_\_\_

Domestic Only (International activities are not covered unless specifically listed and applicable premium charged.)  
Please Note: Coverage is not extended to include bungee jumping, rock climbing, or cliff diving. Coverage may be extended to include out of country mission/international trips, ski trips, and skateboarding events for an additional premium.

Activity	Age Group	Number of Members	Group Premium
Volunteers (Mainly Clerks, Aides, etc)	16 - 70	50	\$3.65/person

Note: The total premium must be submitted with this Addendum Total Premium: \$ 788.00 MP

**SPECIAL NOTES: SUBJECT TO A \$788.00 MINIMUM PREMIUM.**

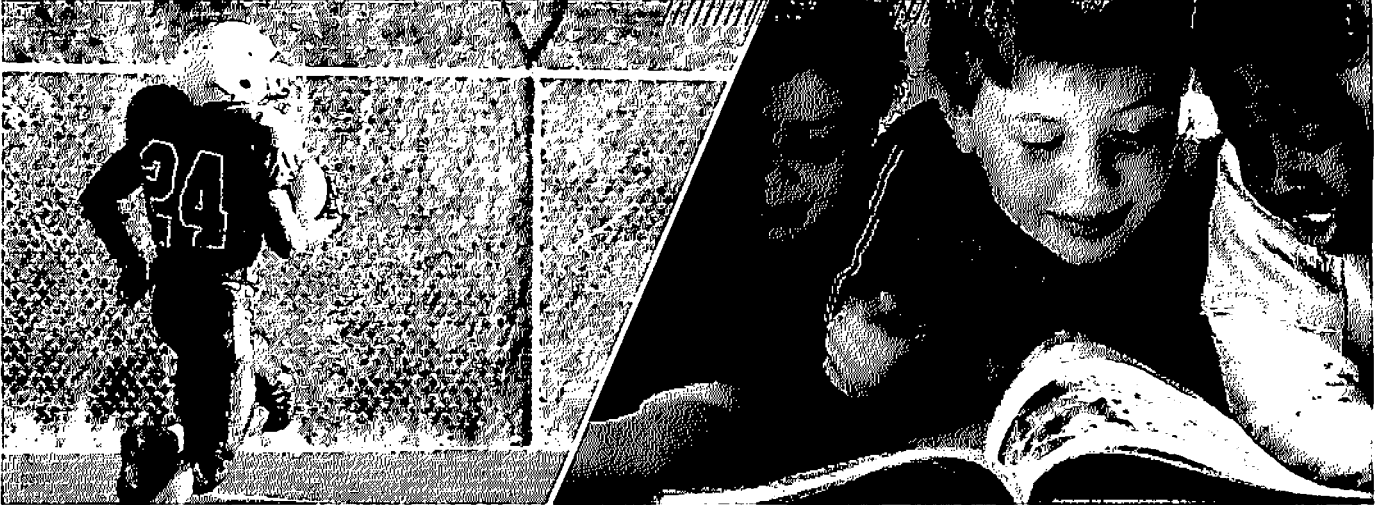
We hereby request from the Company, a Blanket Accident Insurance Policy. We understand that insurance will be in force as of the effective date indicated above, if this Addendum is accepted by the Company and the required premium is received by the Company when due. We acknowledge that we have read, understood, and agreed to the terms and conditions of coverage as detailed in this document.

Official's Name:	Valde Guerra	Title:	Executive Director	Telephone:	956-292-7025
	(please print)				
Signature:	Date of Request:				

<p align="center"><b>The Maksin Group</b> Two Aquarium Drive, Suite 200 Camden, NJ 08103 (800) 375-6826 Fax: (856) 858-1121 <a href="http://www.maksin.com">www.maksin.com</a></p>	Agency Name:	Montalvo Insurance Agency			
	Tax I.D. or SSN:	74-2143288			
	Address	208 S. Texas Blvd.		Telephone: 956-968-5521	
	City:	Weslaco	State:	TX	Zip Code: 78596
	Signature (Licensed Agent):				
	Print Name:		Ramon Montalvo, III		
E-mail:		ramon@montalvoinsurance.com			

Agent Commission \_\_\_\_\_ New \_\_\_\_\_ Renewal  RO \_\_\_\_\_ RO/SUB \_\_\_\_\_ SALES REP \_\_\_\_\_

**AMATEUR SPORTS/GROUP ACTIVITIES  
ACCIDENT PROGRAM**



**CHARTIS**

**Educational Markets**

**New Jersey Regional Office**

**(800) 375-6826**

**South Carolina Regional Office**

**(800) 222-6491**

**Texas Regional Office**

**(800) 285-8133**

This brochure provides only brief descriptions of the coverages available under Policy Series C11695DBG. The Policy will contain reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern in all cases. Coverage may not be available in all states. The policy will include any applicable mandated benefits, provisions or limitations required by the state in which it is delivered.

**Underwritten By**

National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY

**IMPORTANT NOTE:** The plan provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical for sickness coverage.

**VISIT US ON THE WEB AT [WWW.STUDENTINSURANCE.COM](http://WWW.STUDENTINSURANCE.COM)**

## AMATEUR SPORTS/GROUP ACTIVITIES ACCIDENT INSURANCE

**Eligibility:** Any enrolled member of the participating organization, including coaches, trainers, managers and group leaders.

**Accident Medical Expense:** When a covered Injury to an Insured results in treatment by a Physician beginning within 90 days after the date of the accident, the Company will pay benefits as shown in the Schedule of Benefits. Only Covered Accident Medical Service(s) expenses incurred by the Insured within the benefit period are covered. The benefit period begins on the date of the accident. The policyholder selects the duration of the benefit period and it applies to all accidents covered by the policy.

**Full Excess:** Benefits are payable to the applicable maximum for Covered Accident Medical Service(s) expenses that are not recoverable from another plan providing Accident Medical Expense Benefits. If the Insured is not covered by another plan providing Accident Medical Expense Benefits, the excess provision shall not apply, and benefits are payable to the limits described in this brochure. (Not available in ID, OK, OR and SD)

**Primary Excess Over \$100:** Benefits are payable for the first \$100.00 of Covered Accident Medical Service(s) expenses. Thereafter, benefits are payable to the applicable maximum for covered expenses above \$100.00 that are not recoverable from another plan providing Accident Medical Expense Benefits. If the Insured is not covered by another plan providing Accident Medical Expense Benefits, the excess provision shall not apply, and benefits are payable to the limits described in this brochure. (Primary Excess is available in amounts over \$100, \$200, \$300, \$400 and \$500.) (Not available in ID, OK, OR and SD)

**Primary:** Benefits are payable up to the policy maximum for Covered Accident Medical Service(s) expenses.

## COVERAGE

All eligible members of the participating organization are insured for covered Injuries which are received while the Policy is in force and occur while:

- (a) participating in sports/activities sponsored and supervised by the participating organization;
- (b) traveling to, during or after such sports/activities as a member of a group in transportation furnished or arranged by the participating organization if specified by the policy.

**Coverage Term:** Insurance for a participating organization takes effect on the date requested or the date coverage is approved and premium is received by the Company, if later, and terminates on the termination date shown therein.

**Renewability:** This is single-term, non-renewable insurance. For coverage during a subsequent outing, activity or season, it is necessary to again request coverage.

**Underwriting:** Name lists are not required, but all organized, sponsored and supervised group members must be insured under the same plan. Coverage during sports pre-season tryouts and spring practice (if selected) will extend to everyone involved.

**Agent Authority:** No agent has authority to change or alter the policy terms, rates, or this brochure. Any change must be approved in writing by an officer of the Company.

## ACCIDENTAL DEATH AND DISMEMBERMENT AND PARALYSIS\* BENEFITS

If a covered Injury to the Insured results within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below (other than Loss of Life in Pennsylvania), benefits will be paid as shown below.

For Loss Of:	
Life .....	\$5,000
Both Hands or Both Feet .....	\$10,000
Sight of Both Eyes .....	\$10,000
One Hand and One Foot .....	\$10,000
One Hand and the Sight of One Eye .....	\$10,000
One Foot and the Sight of One Eye .....	\$10,000
Speech and Hearing in Both Ears .....	\$10,000
One Hand or One Foot .....	\$5,000
The Sight of One Eye .....	\$5,000
Speech or Hearing in Both Ears .....	\$5,000
Hearing in One Ear .....	\$2,500
Thumb and Index Finger of the Same Hand .....	\$2,500
*Quadriplegia .....	\$10,000
*Paraplegia .....	\$7,500
*Hemiplegia .....	\$5,000
*Uniplegia .....	\$2,500

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Quadriplegia" means the complete and irreversible paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Uniplegia" means the complete and irreversible paralysis of one limb. "Limb" means entire arm or entire leg.

\*Paralysis Benefits are available (except in New York) upon request for an additional premium. Please contact Chartis for details regarding Paralysis Benefits in New York.

If more than one Loss, other than for Loss due to Paralysis, is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid. If the Insured suffers more than one type of paralysis as a result of the same accident, only one amount, the largest, will be paid.

# ACCIDENT MEDICAL EXPENSE INSURANCE

## BENEFIT SCHEDULE (Subject to the Maximum Benefit Amount)

UP TO A TWO YEAR BENEFIT PERIOD	
<b>INPATIENT HOSPITAL SERVICES</b> 1. Daily Room and Board: Semi-Private while Hospital Confined 2. Intensive Care Room and Board 3. Miscellaneous Services: During Hospital Confinement, including all services billed by the facility	100% U & C 100% U & C 100% U & C
<b>OUTPATIENT HOSPITAL SERVICES</b> 1. Emergency Room: When Hospital Confinement is not required, including all services billed by the facility 2. Ambulatory Medical Centers and Outpatient Operating Room	100% U & C 100% U & C
<b>PHYSICIAN'S SERVICES</b> 1. Surgery, including pre- and post-operative care: When a covered injury requires 2 or more covered surgical procedures which are performed through the same approach and at the same time or immediate succession, the Company will pay full value for the most expensive procedure and 50% of the value for the 2nd procedure performed and 25% of the value for any additional procedures performed. 2. Anesthesia (including administration) and Assistant Surgeon when medically necessary 3. Physician's visits other than for Physiotherapy or similar treatment when no surgery benefit is paid: Beginning on the first day treatment is rendered 4. Consultant and second opinions when required by attending Physician for confirming or determining a diagnosis, but not for treatment	100% U & C 100% U & C 100% U & C 100% U & C
<b>X-RAY, MRI AND LABORATORY SERVICES</b> 1. X-rays including fee for interpretation and/or reading of x-rays (Dental x-rays are payable under dental services benefits shown below.) 2. Laboratory services 3. MRI/CatScan	100% U & C 100% U & C 100% U & C
<b>ADDITIONAL SERVICES</b> 1. Physiotherapy or similar treatment including Diathermy, Ultrasound, Microtherm, Manipulation, Massage and Heat: While Hospital Confined Out of Hospital 2. Registered or licensed Nurse in or out of Hospital when medically necessary and prescribed by a Physician 3. Ambulance to initial treatment facility 4. Durable Medical Equipment when prescribed by a Physician including rental of crutches or a wheelchair In Hospital Out of Hospital 5. Drugs and medications, when prescribed by a Physician 6. Eye Glasses, Contact Lenses and Hearing Aids: Replacement of broken glasses and/or frames, contact lenses and hearing aids resulting from a covered injury requiring medical or surgical treatment	100% U & C 100% U & C 100% U & C 100% U & C 100% U & C 100% U & C 100% U & C 100% U & C
<b>DENTAL SERVICES</b> Treatment, repair or replacement of each injured natural tooth: This will include Expenses Incurred for initial braces when required for treatment of a Covered Injury, examination, diagnosis, X-Rays, restorative treatment, endodontics, and oral surgery, and treatment for gingivitis resulting from trauma.	100% U & C

## EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.
3. the Insured's commission of or attempt to commit a felony.\*
4. declared or undeclared war, or any act of declared or undeclared war.\*
5. participation in any team sport or any other athletic activity, except participation in a Covered Activity as defined by the policy.\*
6. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)\*
7. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured is:
  - a. riding as a passenger in any aircraft not licensed for the transportation of passengers for hire.
  - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft.\*
8. any condition for which the Insured is entitled to benefits under any Workers' Compensation Act or similar law.\*
9. the Insured being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.\*
10. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless due to a covered Injury. Applicable to Accident Medical Expense Only.
11. new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement as a result of Injury up to the Dental Maximum shown in the Benefit Schedule.\* Applicable to Accident Medical Expense Only.
12. new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eye glasses or contact lenses unless due to a covered Injury. Applicable to Accident Medical Expense Only.
13. new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless due to a covered Injury. Applicable to Accident Medical Expense Only.
14. rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense in lieu of such rental expense).\* Applicable to Accident Medical Expense Only.
15. any charge for medical care for which the Insured is not legally obligated to pay.\* Applicable to Accident Medical Expense Only.
16. care, treatment or services provided by an Insured or by an Immediate Family Member.\* Applicable to Accident Medical Expense Only.
17. routine physical exam and related medical services.\* Applicable to Accident Medical Expense Only.
18. personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals while confined in a Hospital.\* Applicable to Accident Medical Expense Only.
19. plastic or cosmetic surgery except for reconstructive surgery on an injured part of the body. Applicable to Accident Medical Expense Only.
20. hernia.\* Applicable to Accident Medical Expense Only.

\*Exclusions may vary depending on the state of issue.

## DEFINITIONS

**Deductible** – means the amount of Usual and Customary Charges for Medically Necessary Covered Accident Medical Services, otherwise payable under the program, that must be incurred by the Insured before Accident Medical Expense benefits become payable. Accident Medical Expense benefits are not payable for charges applied to the Deductible.

**Durable Medical Equipment** – refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

**Hospital** – means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except if there is a legal obligation to pay.\*

**Injury** – means bodily injury caused by an accident that: (1) occurs while the Policy is in force as to the person whose injury is the basis of claim; (2) occurs while such person is participating in a Covered Activity; and (3) results directly and independently of all other causes in a covered loss.

**Insured** – means a person: (1) who is a member of an eligible class of persons; (2) for whom premium has been paid; and (3) while covered under the Policy.

**Medically Necessary** – means a Covered Accident Medical Service that: (1) is essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.\*

**Physician** – means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

**Usual and Customary Charges (U & C)** – means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, service or supplies in the locality where the expense is incurred; (3) is a negotiated fee; and (4) does not include charges that would not have been made if no insurance existed.\*

\*Definitions may vary depending on the state of issue.

## HIGHLIGHTS

- Claim service with toll-free lines
- Computerized claim runs available
- No name list required

## OTHER PRODUCTS AVAILABLE

CATASTROPHIC MEDICAL INSURANCE PLAN

CATASTROPHIC CASH DISABILITY BENEFIT

MEDICAL EVACUATION AND REPATRIATION BENEFIT

Please contact Chartis for complete details about these products.

### NEW BUSINESS QUOTE REQUEST FORM

Name of Group \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City

State

Zip Code

Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Type of Activity \_\_\_\_\_ # of Participants \_\_\_\_\_

Type of Sport \_\_\_\_\_ # of Participants \_\_\_\_\_

# of teams: \_\_\_\_\_ Ages: \_\_\_\_\_ 12 & Under \_\_\_\_\_ 13-15 \_\_\_\_\_ 16-18 \_\_\_\_\_ 19 & Over

Camps:  Day  Overnight  Sport  Non-Sport (check all that apply)

Camp Dates: \_\_\_\_\_ # of participants per week: \_\_\_\_\_

**Additional Information:**

\_\_\_\_\_

\_\_\_\_\_

**Local Agent**

Company Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City

State

Zip Code

Contact Person \_\_\_\_\_ Email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_