ACTIVITES	DATE BEGINS	TO	DATE ENDS	ESTIMATED # OF PARTICIPANTS	AGES FROM-TO
Children's Insurance	10/1/24 - 9/30/25			1354	12 mths - 5 yrs

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 is guilty of insurance fraud.

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EXCLUSIONS

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's Compensation or Employer's Liability Laws. (In NC, benefits are excluded if the employer, employee or carrier is responsible or liable according to final adjudication or settlement order under state law)
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. (In ID, an insured person must be participating as a professional)
4. Replacement of contact lenses, eyeglasses, hearing aids or prescriptions or examinations thereof.
5. In Ohio - Reinjury if the insured participated in a covered activity against medical advice.

TO FILE A CLAIM

1. The Policyholder **must** complete Part A of the claim form for all accidents. The parent/guardian or insured must complete **all** questions in Part B or Part C of the claim form.
2. The parent/guardian or insured must:
   a) Obtain copies of the insured's **itemized bills**. The bills must contain the procedure codes, diagnosis codes, and tax ID and NPI numbers of the provider. Do not submit monthly balance due statements.
   b) Submit the insured's itemized bills to the family medical or dental coverage first. This plan is designed to be supplemental to all other valid coverage. The other insurance plan will send a report called Explanation of Benefits (EOB).
   c) Send the completed claim form, copies of insured's itemized bills and EOBs to:

STUDENT ASSURANCE SERVICES, INC.
PO BOX 196
STILLWATER MN 55082-0196
(For 2. b) and c) above, coverage is primary in ID, SD)

For claim questions contact Student Assurance Services at (800) 328-2739 or (651) 439-7098 between 8:00 am and 4:30 pm Central standard time, Monday thru Friday.

TO APPLY FOR COVERAGE

1. Complete and return the attached application, with the estimated number of participants and the premium amount. The premium payment must be returned with the application.
2. The Master Policy and company claim form will be sent to the Policyholder.
3. Make checks payable and mail to:

THE BROKERAGE STORE
4114 Pond Hill Road • Suite 100
San Antonio, TX 78231

PREMIUMS

See Agent Proposal

Policy GA-2200Ed.11-16 (ID)(LA)(MN)
(MT)(NC)(OH)(SD)(TX)

ACCIDENT INSURANCE

for

Special Risk Programs
Sport Camps
Amateur Sports Programs
Rec & Park Programs

MARKETED BY

THE BROKERAGE STORE

David Cates - Texas Representative
The Brokerage Store
4091 De Zavala Road • Suite 3
San Antonio, TX 78249
210-366-4800 or Toll Free 800-366-4810
www.thebrokeragestore.com

UNDERWRITTEN BY

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

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Accident Insurance for Special Risk

STUDENT ASSURANCE SERVICES
C-9712SRGEN-B(2017)TX (SRGEN)

COVERAGE OPTIONS

This insurance plan provides benefits for covered medical expenses resulting from bodily injury caused directly by accident, independent of all other causes, sustained while the participant is:

a) practicing, playing, or participating in a special risk activity while under the supervision of a Policyholder's employee; and
b) traveling to or from such special risk activity while under the supervision of a Policyholder's employee.

The Policy provides a maximum benefit up to $25,000 per injury and covers all special risk activities sponsored and supervised by the Policyholder.

All participants must purchase coverage. (In OH, a participant is a student)

The Medical Benefits and Exclusions apply to Coverage Options above.

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 GA-2200Ed.11-16 (and any state specific), and any applicable endorsement(s). This policy is considered term accident insurance (except in ID) 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 Policyholder as stated on the application. A copy of the Privacy Notice and Certificate of Coverage (where applicable) will be sent to the policyholder.

MEDICAL BENEFITS

When injury covered by the Policy results in treatment by a licensed physician within 60 days from the date of injury, the Company will pay the usual and customary charges (U&C) incurred for covered services below, for expenses incurred within one year from the date of injury up to a **maximum benefit of $25,000 per injury.**

This insurance plan is secondary to all other valid coverage. A claim must be filed with other valid coverage first! (This coverage is primary in ID, SD) This plan does not cover penalties imposed for failure to use providers preferred or designated by the primary coverage. (In NC, other valid coverage does not include automobile or liability coverage)

Unless stated otherwise, amounts listed below are per injury.

PHYSICIAN'S SERVICES
a) **Surgical Care** (surgeon, assistant surgeon, anesthesia).....U&C, up to $2,500
b) **Nonsurgical Care** (includes physiotherapy treatment performed other than in a hospital, 1 visit per day).....U&C, up to $100 per visit, maximum 10 visits

HOSPITAL CARE
a) **Inpatient Care**
1) **Hospital Semi-Private Room** .....U&C, up to $700 per day
2) **Hospital Miscellaneous Services**.....U&C, up to $1,000

b) **Outpatient Care**
1) **Facility Charges for Day Surgery** .....U&C, up to $1,000
2) **Emergency Room** .....U&C , up to $1,000

Note: Benefits for hospital miscellaneous and outpatient care are limited to services not scheduled under Medical Benefits.

X-RAY SERVICES
(includes charges for reading) ..... U&C, up to $300

DIAGNOSTIC IMAGING (MRI, CT Scan, bone scan, includes 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 SD, sound and natural is deleted)
(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. (In OH, this provision does not apply)

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.

APPLICATION FOR SPECIAL RISK ACCIDENT INSURANCE

Ameritas
Ameritas Life Insurance Corp.
Lincoln, Nebraska

Name of Policyholder Webb County Head Start Program
Street Address P.O. Box 2397 City Laredo State Tx Zip 78041
List the Activities for which this application applies on the back of this form. Effective Date 10/1/2024 Expiration Date 9/30/2025
Number of Participants 1354 X $ 5.00 = $6,770 Total Premium Enclosed $ $6,770.00
(Rate per insured) (Sub Total) (Minimum Premium $ _____)
Applied for by: Name(please print) Judge Tano Tijerina Title Webb County Judge
e-mail address _____ Phone _____ Date _____
Signature X _____
I certify the information recorded on this application is the information provided by the Applicant.
Agent The Brokerage Store, Inc. 800 - 366-4810
Print Name Phone Number E-Mail Address
4091 De Zavala Road, Suite 3, San Antonio,Tx 78249
Agent Mailing Address

*The maximum term of coverage at this premium rate is 3 months. If longer term of coverage is needed, please contact our office for rates.

PLEASE SEND APPLICATION AND PREMIUM PAYMENT TO:
THE BROKERAGE STORE, 4091 De Zavala Road • Suite 3, San Antonio, TX 78249
Phone Toll Free (800) 366-4810

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