Diocese of Pensacola / Tallahassee

Voluntary Student Accident Insurance Plan • MCB 5466270

The following is a brief description of the Voluntary Student Accident Insurance Plan. The benefits described are subject to certain limitations and exclusions as described in the policy. For specific definitions of terms used below as well as further details and information about this Plan, please see the policy. You must enroll for this voluntary coverage. An enrollment form is attached to this material.

Eligibility

Class II: All students of the policyholder who elect voluntary coverage and for whom the premium has been paid:

Grades: Pre-K – 12 and Daycare
(Includes enrolled and non-enrolled students participating in summer camps, RCIA program, youth programs, CCD, Catholic Charities)

Covered Activities

Class II: Optional 24-Hour Wrap Around Accident Coverage: While participating in a sport and/or activity that is not covered under a compulsory plan provided by the policyholder.

(Coverage includes weekends, vacations, coverage at home or away)

Benefit Amount

Accidental Death Benefit: $30,000

Accidental Dismemberment Benefit:..... $30,000 maximum

Exposure and Disappearance Benefit: $30,000

Accidental Excess Integrated Medical Expense Benefit: ..... $25,000 maximum benefit

..... $0 deductible per insured per covered accident

..... 65% Our share of Usual and Customary expenses per Insured per Covered Accident

Heart Failure Benefit:..... $10,000 maximum benefit

Benefits Provided

Accidental Death Benefit

If you suffer a loss of life as a result of a covered injury, we will pay the applicable amount shown in the policy schedule. Your death must occur within 365 days of your covered injury.

Accidental Dismemberment Benefit

If your covered injury results in any of the following covered losses, we will pay the percentage shown below. Your covered loss must occur within 365 days of your covered accident.

The benefit amount is based on the maximum amount shown in the policy schedule for the person suffering the Covered Loss.

Covered Loss of	Percentage of Maximum Amount
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Hand or One Foot plus the loss of Sight of One Eye	100%
Sight of Both Eyes	100%
Speech and Hearing	100%
Speech or Hearing	50%
One Hand; One Foot; or Sight of One Eye	50%
Thumb and Index Finger of the same Hand	25%
Hearing in One Ear	25%

For purposes of this Benefit **Covered Loss** means:

1. For a foot or hand, actual severance through or above the ankle or wrist joint;
2. For thumb and index finger, complete severance through or above the metacarpophalangeal joint of both digits;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

Exposure and Disappearance Benefit

If you are exposed to weather because of an accident and this results in a covered loss, we will pay the applicable amount shown in the policy schedule subject to all policy terms.

If the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event, we will presume that you lost your life as a result of injury. If travel in such conveyance was covered under the terms of the policy, we will pay the applicable amount shown in the policy schedule, subject to all policy terms. We have the right to recover the benefit if we find that you survived the event.

Accident Excess Integrated Medical Expense Benefit

We will pay our share of the usual and customary expenses (reduced by payment on any other insurance plan) for Medically Necessary Covered Medical Service(s) (as defined in the policy) incurred by you resulting from a Covered Accident while participating in a covered activity, up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that: 1) the first treatment or service occurs within ninety (90) days of the covered injury; and 2) the medical expenses are incurred within fifty-two (52) weeks of the covered injury.

Heart Failure Benefit

If you suffer a covered injury resulting in a covered loss as a result of a covered accident, which is a result of a Heart Failure, We will pay an additional amount shown in the Schedule. The Heart Failure must occur within twenty-six (26) weeks of the covered accident.

To File a Claim

Contact Administrative Concepts, Inc. at 1-888-293-9229 for a claim form. Complete the form and send it to ADMINISTRATIVE CONCEPTS, INC., 994 Old Eagle School Rd, Suite 1005, Wayne, PA 19087-1802 within 90 days of the loss. Refer to Plan Number MCB 5466270.

Beneficiary Designation

Covered losses resulting from your death are paid to your named beneficiary at the time of death. If there is no beneficiary named or your named beneficiary predeceases or dies at the same time as you, we will pay the benefit to your survivors in the following order: a)

your spouse/domestic partner; b) your child(ren); c) your parents; d) your brothers and sisters; or e) your estate: All other claims will be paid to you.

Payment for a Foreign National

If you are a citizen of a country or jurisdiction other than the United States of America and are not a resident of the United States of America and are entitled to benefits for a covered loss and we are unable to make payment directly to you because of legal restrictions in the country or jurisdiction where you are located, we will either: (1) pay the benefits to a bank account owned by you in the United States of America; or (2) if no such bank account is established or maintained, we will pay the benefits to the policyholder on your behalf. It will then be the responsibility of the policyholder to remit the benefit to you. Payment of the benefit to the policyholder will release us from any further liability to you. If the policyholder does not remit the payment to you, the policyholder will indemnify us and hold us harmless against any and all liability incurred by us including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The policyholder will not be considered the beneficiary under the policy if payment is made to the policyholder in accordance with this provision.

Exclusions

A loss shall not be a covered loss if it is caused by, contributed to, or resulted from:

1. suicide or any attempt at suicide while the Insured was sane or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. war or any act of war, whether declared or undeclared.
3. involvement in any type of active military service. For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service.
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for accidental ingestion of contaminated foods.
5. participation in the commission or attempted commission of any felony, an assault, insurrection or riot.
6. being intoxicated while operating a motor vehicle.
    a. You will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be intoxicated, if operating a motor vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of your intoxication.
7. being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.
8. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
9. participation in any team sport or any other athletic activity unless mentioned in the **Covered Activities**.
10. any condition for which you are paid benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.

General Limitations

Benefits are payable only for covered losses incurred as a result of participation in covered activities.

Limitation on Multiple Covered Losses: If you suffer more than one covered loss as a result of the same accident, we will pay only one benefit, the largest benefit.

Limitation on Multiple Covered Activities: If you suffer a covered loss while participating in more than one covered activity, we will pay only one benefit, the largest benefit unless there is a specific written exception in this policy.

Limitation of Multiple Benefits: If you can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same accident, we will pay only one benefit, the largest benefit.

Limitation on Mulitple Covered Poliices: If you can recover benefits under more than one accident policy written by Zurich American Insurance Company, we will pay under only one policy, the policy which offers you the largest benefit.

Additional Exclusions for the Accident Excess Integrated Medical Expense Benefit

In addition to the General Exclusions stated in the policy, we will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless medically necessary for the treatment of the covered injury.
2. Any medical expenses related to pregnancy unless medically necessary for the treatment of the covered injury.
3. Covered injury for which you are paid benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
4. Personal comfort or convenience items, such as but not limited to hospital telephone charges, television rental, or guest meals.
5. Treatment by any immediate family member or member of your household.
6. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless medically necessary for the treatment of the covered injury.
7. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless medically necessary for the treatment of the covered injury.
8. Routine physical examinations and related medical services.
9. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
10. Expenses which you are not legally obligated to pay.
11. Expenses for custodial services or services provided by a private duty nurse unless such expenses are incurred as a result of a covered injury.
12. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the covered injury has caused further impairment of the underlying bodily condition.
13. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a covered injury.
14. Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.

Important

This is a brief description of the coverage provided through the participant accident plan. If any conflict should arise between the contents of this handout and the master policy or if any point is not covered herein, the terms of the master policy shall govern in all cases.

Zurich

1400 American Lane, Schaumburg, Illinois 60196-1056
800-382-2150 www.zurichna.com

The terms and conditions of the Plan described in this brief summary are governed by the individual Plan document that contains the complete terms. In the event of any discrepancy between the information in this brief summary and the Plan document, the Plan document shall govern.

Insurance coverages underwritten by member companies of Zurich in North America, including Zurich American Insurance Company. Certain coverages not available in all states. Some coverages may be written on a nonadmitted basis through licensed surplus lines brokers.

Enrollment Form

Blanket Accident Insurance

Mail Enrollment form with Check (made out to Zurich North America) to:
ACI
Attention: Zurich Voluntary Benefit Department
994 Old Eagle School Road, suite 1005
Wayne. PA 19087-1802

Customer Service: 888.293.9229

A certificate of Coverage will be sent to all enrolled Students / Parents.

POLICYHOLDER INFORMATION			
Name of **Policyholder**: Diocese of Pensacola / Tallahassee			Master Policy Number: MCB 5466270
ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):			Last 4 Digits of SSN: XXX-XX-
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female		
Email Address:	Home Phone: - -	Cell Phone: - -	
PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):			Relationship to Enrollee: ☐ Parent ☐ Legal Guardian
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

PREMIUM INFORMATION:	
Enrollee:	
Annual Premium Option:	$82.00

Enrollment by Mail
Please fill out this Enrollment Form and mail with your check for $82.00 made out to Zurich North America to the following address: ACI, Attention: Zurich Voluntary Benefit Department, 994 Old Eagle School Road, suite 1005 Wayne. PA 19087-1802

It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic): Date:

Parent or Legal Guardian's Signature (may be electronic): Date: