

SERFF Tracking Number: AEGX-126458195 State: Arkansas
Filing Company: Monumental Life Insurance Company State Tracking Number: 44597
Company Tracking Number: GH AR0047655F01
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Student Health
Project Name/Number: Student Health/GH AR0047655F01

Filing at a Glance

Company: Monumental Life Insurance Company

Product Name: Student Health

SERFF Tr Num: AEGX-126458195 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-
Closed State Tr Num: 44597

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: GH AR0047655F01 State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Rosalind Minor

Date Submitted: 01/15/2010

Disposition Date: 06/16/2010

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Student Health

Status of Filing in Domicile: Not Filed

Project Number: GH AR0047655F01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: To be filed.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Blanket

Filing Status Changed: 06/16/2010

Explanation for Other Group Market Type:

State Status Changed: 02/23/2010

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

The attached forms are being filed for your review and approval. These are new forms and do not replace any existing form.

This Blanket Student Accident Insurance Policy will be issued direct in your state and will be offered to School Boards to provide accident coverage to students in grades kindergarten through 12. The items within the [] brackets indicate language that will either be included or deleted from the forms. The items within the { } brackets indicate language that will change.

These forms offer plans with a coinsurance percentage and/or an out of pocket maximum option. The coinsurance

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percentage and out of pocket maximum option are bracketed and will only be used with our Compulsory plans.

All SERFF filing submission requirements have been met.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions or need any additional information, please do not hesitate to contact me. Thank you in advance for your help and attention to this matter.

Company and Contact

Filing Contact Information

Mary DiMarcantonio, Product Filing & Compliance Analyst
 520 Park Avenue
 Baltimore, MD 21201
 mdimarcantonio@aegonusa.com
 410-209-5263 [Phone]
 410-209-5910 [FAX]

Filing Company Information

Monumental Life Insurance Company
 4333 Edgewood Road, N.E.
 Cedar Rapids, IA 52499
 (800) 553-5957 ext. [Phone]

 CoCode: 66281
 Group Code: 468
 Group Name:
 FEIN Number: 52-0419790
 State of Domicile: Iowa
 Company Type: Life and Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company	\$50.00	01/15/2010	33565510

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/16/2010	06/16/2010
Approved-Closed	Rosalind Minor	02/23/2010	02/23/2010
Approved-Closed	Rosalind Minor	01/26/2010	01/26/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/22/2010	01/22/2010	SPI ADMSLH	01/26/2010	01/26/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Master Application	SPI ADMSLH	06/16/2010	06/16/2010
Form	Policy Endorsement	SPI ADMSLH	02/22/2010	02/22/2010

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Disposition

Disposition Date: 06/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

This submission was reopened in order to replace the master application with a new form number. The replaced application is approved effective on this date. The remainder of the submission will retain the original approval date.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Explanation Of Variability	Approved-Closed	Yes
Supporting Document	AR - SERFF ONLY - FILING AT A GLANCE	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Blanket Student Accident Only Insurance Policy	Approved-Closed	Yes
Form (revised)	Policy Endorsement	Approved-Closed	Yes
Form	Policy Endorsement	Replaced	Yes
Form (revised)	Master Application	Approved-Closed	Yes
Form	Master Application	Replaced	Yes

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Product Name: Student Health
Project Name/Number: Student Health/GH AR0047655F01

Disposition

Disposition Date: 02/23/2010

Implementation Date:

Status: Approved-Closed

Comment:

The revised Form MLSA2101GBER is approved effective on this date.

The remainder of the filing will maintain the original approval date of 1/26/10.

Rate data does NOT apply to filing.

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Disposition

Disposition Date: 01/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 01/22/2010

Submitted Date 01/22/2010

Respond By Date

Dear Mary DiMarcantonio,

This will acknowledge receipt of the captioned filing.

Objection 1

- Master Application, MLSA2100GBMA (Form)

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Project Name/Number: Student Health/GH AR0047655F01

Response Letter

Response Letter Status Submitted to State
Response Letter Date 01/26/2010
Submitted Date 01/26/2010

Dear Rosalind Minor,

Comments:

This is in response to your objection letter dated 1/22/10.

Response 1

Comments: The application form submitted is a group master application. This application will be completed by the account when they contract with Monumental Life Insurance Company to provide this coverage to their students. By completing this application, the account is choosing the coverage that will be made available to the students.

Based on the above, it would appear that the fraud warning notice would not be required on this application.

Related Objection 1

Applies To:

- Master Application, MLSA2100GBMA (Form)

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope that this answers your objection and that we will soon receive your notice of approval. Should you need any additional information, please let me know.

Sincerely,

Mary J. DiMarcantonio, ALHC

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Project Name/Number: Student Health/GH AR0047655F01
1-800-233-4624

Sincerely,
SPI ADMSLH

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 Project Name/Number: Student Health/GH AR0047655F01

Amendment Letter

Submitted Date: 06/16/2010

Comments:

Dear Ms. Minor:

Attached, please find a revised master application form MLSA2100GBM which is replacing the previously approved form. The only change to this form is to the form number which has been revised to show MLSA2100GBMA. The form number on the previously filed and approved form was incorrect and did not match the form number referenced in the filing.

Please be assured that the previously approved version of this form has not been issued in Kansas or otherwise used in Kansa and will not be used in Kansas at anytime.

Should you need any additional information, please contact me. Thank you for your help and cooperation with this filing.

Sincerely,
 Mary J. DiMarcantonio, ALHC
 Policy Filing and Compliance Analyst
 1-800-233-4624 Ext. 5263
 mdimarcantonio@aegonusa.com

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MLSA2100G	Application/EMaster	Application	Initial				56.700	MLSA2100GB MA Master Application.P DF

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 Product Name: Student Health
 Project Name/Number: Student Health/GH AR0047655F01

Amendment Letter

Submitted Date: 02/22/2010

Comments:

As per our phone conversation, a revised Policy Endorsement form, MLSA2100GBER, is attached. This form has been changed to revise the areas which may be amended, and to also show the variations within this form. This form will be used to add an additional policy term, to change the Policyholders address, or to change the groups covered.

As we discussed, this form has not been used and therefore, we would like to keep the same form number.

Thank you for your help and cooperation.

Sincerely,

Mary J. DiMarcantonio, ALHC
 Policy Filing and Compliance Analyst
 1-800-233-4624 Ext. 5263
 mdimarcantonio@aegonusa.com

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MLSA2101GBER	Certificate Amendment, Insert Page, t Endorsemen t or Rider	Policy	Initial				0.000	MLSA2101GBER.PDF

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Form Schedule

Lead Form Number: MLSA2100GBP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 01/26/2010	MLSA2100 GBP	Policy/Cont ract/Fratern al	Blanket Student Accident Only Insurance Policy Certificate	Initial		40.000	MLSA2100G BP.PDF
Approved- Closed 02/23/2010	MLSA2101 GBER	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Policy Endorsement	Initial		0.000	MLSA2101G BER.PDF
Approved- Closed 06/16/2010	MLSA2100 GBMA	Application/ Enrollment Form	Master Application	Initial		56.700	MLSA2100G BMA Master Application.P DF



(Herein, "We," "Us," "Our" or the Company)

Hereby issues to the School this Policy insuring the persons of the School, herein called the Insured. The Company agrees to pay the described benefits in this Policy. Coverage is subject to provisions for Injuries received while the Insured is:

- (a) participating in or attending any School Sponsored and Supervised Activity. The activity must be supervised by an authorized representative of the School;
- (b) traveling directly and uninterruptedly to and from such School Sponsored and Supervised Activity with other members as a group. Such travel must be supervised by an authorized representative of the School;
- (c) traveling directly and uninterruptedly to or from the Insured's home and the meeting place for the purpose of participating in a School Sponsored and Supervised Activity.

[Further, in consideration of payment of the premium for 24-Hour Coverage, this insuring clause is amended to include the following:

- (d) engaged in activities other than those named in paragraphs (a) through (c) above, except for those activities specifically excluded by the Policy or by any endorsements.]

ALL BENEFITS AND EXCLUSIONS ARE DESCRIBED HEREIN.

This Policy is issued in consideration of (a) the attached application made a part hereof; and (b) payment of premium as set forth.

Signed for the Company at its Home Office, Cedar Rapids, Iowa.

NON-PARTICIPATING
BLANKET STUDENT ACCIDENT ONLY POLICY

[LIMITED BENEFIT, PLEASE READ CAREFULLY]

MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa

A handwritten signature in black ink that reads "Stacy Boyer".

Secretary

A handwritten signature in black ink, appearing to be "H. S. Boyer".

President

MLSA2100GBP

TABLE OF CONTENTS

[ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT	{10}
CLAIM PROVISIONS.....	{14}
DEFINITIONS	{5}
[DENTAL COVERAGE BENEFIT	{10}
EFFECTIVE DATE, POLICY TERM AND POLICY TERMINATION.....	{13}
EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL VOLUNTARY PARTICIPATION STUDENT ACCIDENT ONLY INSURANCE.....	{13}
EXCLUSIONS.....	{8}
GENERAL PROVISIONS.....	{13}
HOSPITAL AND PROFESSIONAL SERVICES BENEFIT	{7}
[PRE-EXISTING.....	{13}
SCHEDULE OF BENEFITS	{3}
STUDENT ACCIDENT ONLY BENEFITS.....	{7}
[STUDENT ACCIDENT ONLY 24-HOUR COVERAGE BENEFIT	{11}
[STUDENT DISABILITY BENEFIT	{12}
[VOLUNTARY PARTICIPATION DENTAL COVERAGE BENEFIT	{11}

SCHEDULE OF BENEFITS

POLICYHOLDER: {ABC School}
POLICY NUMBER: {MZ 00-000}
EFFECTIVE DATE: {August 1, 2010}
TERMINATION DATE: {August 1, 2011}

APPLIES TO:

- 1. [All School Sponsored and Supervised Activities including all interscholastic sports,]
- 2. [All School Sponsored and Supervised Activities including [senior high school] tackle football,]
- 3. [All School Sponsored and Supervised Activities excluding all interscholastic sports,]
- 4. [All School Sponsored and Supervised Activities including all interscholastic sports except tackle football,]
[Interscholastic sports including [senior high school] tackle football,]
- 5. [Interscholastic sports except tackle football,]
- 6. [Interscholastic [senior high school] tackle football only,]
- 7. [Voluntary participation school time and 24-hour plans including all interscholastic sports except tackle football,]
- 8. [Voluntary participation school time and 24-hour plans excluding all interscholastic sports,]
- 9. [Voluntary student dental plan,]
- 10. [Specifically named student group(s), team(s), club(s), event(s), trip(s), as specified by the Policyholder].

Maximum Medical Expense Benefit [for each Injury]: {\$5,000 - \$5,000,000}

Benefit Period[s]:
[{\$10,000 - \$5,000,000} MAXIMUM BENEFIT WITH A {1-10} [YEAR] [OR LIFETIME] BENEFIT PERIOD UNDER ATHLETIC PLAN]

[{\$10,000 - \$500,000} MAXIMUM MEDICAL EXPENSE BENEFIT WITH A {1-5} YEAR BENEFIT PERIOD UNDER VOLUNTARY STUDENT PLAN]

[UP TO {\$10,000-\$5,000,000} MAXIMUM BENEFIT WITH {1-10} [YEAR] [LIFETIME BENEFIT] PERIOD UNDER COMPULSORY STUDENT PLAN]

Coverage will be provided only for the benefits specified below.

STUDENT ACCIDENT ONLY SCHEDULE OF BENEFITS:

BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICES:

Initial treatment must be rendered within {15 - 60} days of the date of Injury, otherwise no benefits are payable.

[Services must be rendered within {1 year - lifetime} from the date of Injury. Expenses incurred after {1 year - lifetime} from the date of Injury are not covered even though the service is a continuing one or one that is necessarily delayed beyond {1 year - lifetime} from the date of the Injury.]

[Benefits will be paid up to a maximum of {\$10,000 - \$5,000,000} for any one Injury, which are in excess of the deductible.]

[The Deductible Amount is the greater of:

1. {\$100 - \$25,000}[, or]
2. [Benefits paid for the same Injury under all Other Valid and Collectible Health Insurance Plans].

[\$100-\$5,000} EXCESS PROVISION: This provision is described in the Student Accident Benefits section.]

[This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.]

HOSPITAL AND PROFESSIONAL SERVICES BENEFIT

Maximum Benefit Limitations:

1. **[AMBULANCE**
[{\$50%-90%} of the] [Usual and Customary Charge][Actual Charge] for services of a licensed ambulance unit are covered [up to a {\$50 - \$25,000} maximum].]
2. **[AMBULATORY SURGICAL CENTER:**
[{\$50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to a {\$50 - \$25,000} [per Accident] maximum].]
3. **[CAT SCAN:**
[{\$50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to a {\$50 - \$25,000} [per Accident] maximum].]
4. **[DENTAL:**
[{\$50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to a maximum of {\$50 - \$25,000} per Accident] [and] [{\$50-\$500} maximum per tooth]. This covers treatment of sound and natural teeth [as well as capped or crowned teeth] [for up to {52 - 260 weeks}] from the date of Accident.]
5. **[[EYEGLASSES] [CONTACTS LENSES] [AND] [HEARING AIDS]:**
[{\$50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to {\$200 - \$500} per Accident [maximum] is allowed for replacement of [eyeglasses,] [contact lenses,] [or] [hearing aids] broken or damaged in a covered Accident in which medical treatment is provided for accidental bodily Injury].]
6. **[[HEAT EXHAUSTION] [and] [SPRAINS]:**
[{\$50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to a {\$50 - \$25,000} [per Accident] maximum][.] [Considered a covered Accident under interscholastic athletics.]]
7. **[HOSPITAL:**
[{\$50% - 90%} of the] [Hospital room and board is covered at the semi-private room rate up to the [Usual and Customary Charge][Actual Charge] [up to a maximum of {\$100 - \$200} per day] [and] [up to a maximum of {5 - 10} days]. [{\$50% - 90%} of the] [Usual and Customary

Charge][Actual Charge] for inpatient miscellaneous (inpatient or as outpatient for day surgery) expenses are covered[.] [up to a {\$1,000- \$25,000} maximum].]

8. [HOSPITAL EMERGENCY ROOM:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] for treatment [within {24-72} hours] of an Injury (including supplies and services except x-rays)].]

9. [MRI:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [up to a {\$50 - \$25,000} [per Accident] maximum].]

10. [NURSING SERVICES:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge], if prescribed by a Physician and the Insured is, Hospital confined[.] [up to a maximum of {\$30 - \$500} per visit][.] [and] [up to a maximum of {5 - 20} visits][.] [up to a {\$200 - \$25,000} maximum].]

11. [ORTHOPEDIC [BRACES] [&] [APPLIANCES]:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge][.] [up to a {\$50 - \$25,000} maximum].]

12. [[OUTPATIENT SERVICES] [AND] [LABORATORY TESTS]:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] [.] [up to a {\$100 - 25,000} maximum].]

13. [PHYSICIAN'S VISITS:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] for non-surgical doctor visits (including office visits) will be paid[.] [up to {\$30 - \$500} maximum [per visit][.] [and] [up to a maximum of {5 - 20} visits] [up to a {\$200 - \$25,000} maximum].]

14. [[PHYSIOTHERAPY] [PHYSICAL THERAPY] [AND/OR] [SPINAL MANIPULATION]:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] for in hospital diathermy, heat treatment, adjustment, manipulation or massage is covered [up to a maximum of {\$25 - \$100} per visit] [and] [up to a maximum of {3 - 365} visits]. Coverage is also provided for necessary treatment in the doctor's office, or by a Sports Medicine Center or similar facility up to the [Usual and Customary Charge][Actual Charge], provided the treatment is rendered by a licensed Physician or registered physical therapist ***, to a maximum of {\$1,000 - 2,000}, unless total medical bills exceed {\$25,000} in which case the maximum limit is removed.***
[BRACKETED PHRASE FOR VOLUNTARY PARTICIPATION PLANS ONLY]

15. [PRESCRIPTION DRUGS:

[[{50% - 90%} of the] [Prescription drugs are covered [in full] up to the] [Usual and Customary Charge][Actual Charge] when prescribed by a Physician for treatment of a covered Accident[.]] [up to a {\$50 - \$25,000} maximum].]

16. [SECOND OPINION:

[[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] is allowed for consultations and second opinions, in cases in which surgery is contemplated[.] [up to a {\$200 - \$25,000} maximum].]

17. [[SURGERY] [AND] [ANESTHESIA]:

[SURGERY - [[{50% - 90%} of the] [Usual and Customary Charge][Actual Charge] is allowed[.] [up to a {\$500 - \$25,000} maximum].]

[ANESTHESIA - [50% - 90%] of the] [surgical benefit] [Usual and Customary Charge][Actual Charge] is allowed[.] [up to a {\$200 - \$25,000} maximum].]

18. [[X-RAYS][AND][DIAGNOSTIC IMAGING]:

[[50% - 90%] of the] [Usual and Customary Charge][Actual Charge] [when billed by provider other than a Hospital][.] [up to a {\$50 - \$25,000} maximum].]

[ACCIDENTAL DEATH[,] [AND][DISMEMBERMENT][, AND LOSS OF SIGHT] BENEFIT:

[[{\$5,000 - \$50,000} will be paid [(as shown in the following schedule)] if death occurs within {100 - 365 days} of the date of Accident.]

[[{\$5,000 - \$50,000} will be paid (as shown in the following schedule) for dismemberment occurring within {100 - 365 days} of the date of Accident.]]

[Loss of Life:	[\$5,000 - \$50,000]
[Loss of Both Hands, Both Feet, or Sight of Both Eyes:	[\$5,000 - \$50,000]]
[Loss of One Hand, One Foot, or Sight of One Eye:	[\$2,500 - \$25,000]]]

DEFINITIONS

ACCIDENT means an unexpected, external and sudden event that is independent of any other cause and occurs while the Insured is covered under this Policy.

[ACTUAL CHARGE means the fee charged by the Physician or Hospital for a covered service.]

COINSURANCE means the amount to be paid by the Insured as a percentage of the covered medical expenses, after the Deductible has been met.

[DISAPPEARING]DEDUCTIBLE means the dollar amount of Covered Medical Expenses [and Covered Dental Expenses] which must be incurred as an out-of-pocket expense [or satisfied by any other benefit plan or combination thereof] by an Insured for each Loss. [The Deductible amount is shown on the Schedule.]]

HOSPITAL means an institution which meets all of the following requirements:

- (1) it must be operated according to law;
- (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
- (3) it must provide diagnostic and surgical facilities supervised by Physicians;
- (4) Registered Nurses must be on 24 hour call or duty;
- (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

IMMEDIATE FAMILY MEMBER means the Insured's spouse, children (includes legally adopted or stepchild), brothers, sisters, uncles, aunts, in-laws, and parents of the Insured and of the Insured's spouse.

INJURY means bodily injury caused by an Accident. The injury must occur while this Policy is in force and while the Insured is covered under this Policy. The injury must be sustained while the Insured is participating in an activity covered by this Policy]

[The term injury also means the treatment of a re-injury, incurred while the Policy is in force with respect to the Insured, for which the Insured has been treatment free for a period of at least {90 - 365} days prior to the effective date of the Master Policy.

If benefits have been paid under the Policy for an injury incurred while the Policy is in force, with respect to the Insured, a re-injury will be considered a new injury if:

- a) The re-injury occurs while the Policy is in force with respect to the Insured; and
- b) The Insured remains treatment free for a period of {90 - 365} days between the date of last treatment for the original injury and the date of the re-injury. A re-injury that is incurred within the {90 - 365} days of the original injury will be considered a continuation of the original injury.]

INSURED means an eligible student as outlined in this Policy [for whom an enrollment form has been received] and has paid the required premium. The words he, his, and him refer to the Insured[, regardless of gender].

LOSS means medical expense covered by this Policy as the result of Injury.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a [Sickness] [or Injury]. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the Insured.

OTHER VALID AND COLLECTIBLE HEALTH INSURANCE PLANS means all other valid and collectible Hospital, medical, dental or surgical coverage providing benefits for covered medical services of the kind described in this Policy. Other Valid and Collectible Group Insurance includes but is not limited to group or blanket insurance policies; Hospital or medical service plan contracts; HMO or other prepayment plans; employee benefit plans; any plan arranged through an employer, labor union, employee benefit association or trustee; any group plan created or administered by the federal or a state or local government or its agencies; or automobile medical payments and no-fault insurance. "Other insurance" shall not include accidental death and dismemberment insurance of any kind.

OUT-OF-POCKET-LIMIT means the total maximum dollar amount that a Covered Person must pay as Deductible and Coinsurance for services and supplies for a covered Injury. All amounts paid as Coinsurance and Deductible shall count towards the maximum Out-Of-Pocket Limit. Once the maximum Out-Of-Pocket Limit is met all services and supplies shall be covered at 100% [of Usual and Customary Charge][Actual Charge] [up to the policy limit] with no Deductible or Coinsurance. Balances over the Usual and Customary Charge and the Deductible do not apply to the Out-Of-Pocket-Limit dollar amount.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts [or social worker]. He must be practicing within the scope of his license for the service or treatment given. He may not be the Insured or a member of his Immediate Family.

PHYSIOTHERAPY means any form of physical therapy, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

POLICY means the contract issued to the Policyholder providing the benefits described.

RESIDENCE means the home and land or property on which the Insured's home is located.

SCHOOL SPONSORED AND SUPERVISED ACTIVITY [REGULARLY SCHEDULED ACTIVITY] means all school functions which are organized and scheduled solely by the school on or off school premises. This would include: (1) classes which are under the sole direct supervision of qualified school authorities; and (2) school sponsored and supervised travel to and from such activities, as provided in the insuring clause.

SURGICAL EXPENSE means (a) a Surgical Procedure; (b) necessary preoperative treatment in connection with such procedure; and (c) usual postoperative treatment.

SURGICAL PROCEDURE means (1) a cutting procedure; (2) suturing of a wound; (3) treatment of a fracture; (4) reduction of a dislocation; (5) electrocauterization; (6) diagnostic and therapeutic endoscopic procedures; and (7) an operation by means of laser beam.

[USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered[.] [and the [Ingenix] schedule of fees valued at the { 90th } percentile [and the Anesthesia Relative Value Guide].]

EXCLUSIONS

Benefits are not paid for:

- [1. Injuries which are not caused by an Accident;]
- [2. Injury sustained as a result of practice or play in senior high interscholastic tackle football, unless the premium for such coverage has been paid;]
- [3. Re-injury or complications of a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a {two year} period preceding the effective date of the coverage of the Insured;]
- [4. Treatment performed by a family member or person retained by the School;]
- [5. Injury due to: acts of war; suicide or intentionally self-inflicted Injury, while sane or insane (in Missouri while sane); violating or attempting to violate the law; taking part in any illegal occupation; fighting or brawling except in self defense; or loss in consequence of being legally intoxicated as defined by the laws of the state in which the loss occurs; or under the influence of any drugs or narcotic unless administered by or on the advice of a Physician;]
- [6. Medical expenses for which the Insured is entitled to benefits under any (1) Worker's Compensation act; or (2) mandatory no-fault automobile insurance contract;]
- [7. Expenses for which there is no obligation to pay;]
- [8. Treatment or Loss resulting from [hernia, regardless of cause,]Osgood Schlatter's disease, or osteochondritis;]
- [9. Injury sustained as a result of operating, riding in or upon, or alighting from an ATV (all terrain vehicle); or any [two], [three] [or] [four] wheeled [recreational] motor vehicle; [or snowmobile]; [or bobsled];]

- [10. Any expense for which benefits are payable under Catastrophic Accident Insurance Program of the State High School Interscholastic Activities Association;]
- [11. Bacterial infections, sickness or disease of any kind such as strep throat or tonsillitis, heat exhaustion, sunburn, frostbite, fainting, allergic reactions, except those which occur as a result of accidental ingestion or pus forming infections which occur through an accidental cut or wound;]
- [12. Vegetation poisoning such as poison ivy or poison sumac, or ptomaine poisoning;]
- [13. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain;]
- [14. Private air travel, to include ballooning or ultra-light aircraft; parachuting; or hang-gliding;]
- [15. Repair or replacement of prescription eye glasses, contact lens or hearing aids;]
- [16. Experimental procedures;]
- [17. Serving in the armed forces of any country or international authority.]
- [18. Expenses incurred for dental implants.]

All benefits are subject to any Deductible and Coinsurance amounts shown on the Schedule of Benefits.

STUDENT ACCIDENT ONLY BENEFITS

HOSPITAL AND PROFESSIONAL SERVICES BENEFIT

Upon receipt of due proof that an Insured incurred expenses for Hospital and Professional Services, we will pay [up to {50% - 90%} of]the [Usual and Customary Charge][Actual Charge] incurred, for a covered Injury, subject to the Maximum Benefit Limitations stated in the Schedule of Benefits, under the Hospital And Professional Services Benefit. Such Injury must be treated within the number of days stated in the Schedule of Benefits. Benefits are paid according to the geographical area where the service is given. Services must be given: (1) by a legally qualified Physician; (2) for necessary medical, dental or Hospital care; and (3) within the time limit stated in the Schedule of Benefits. Benefits are paid to the maximum stated in the Schedule of Benefits for any one Injury, which are in excess of the Deductible Amount. [The insured will have an Out-Of-Pocket-Limit of {\$500 - \$7,500} per covered Injury. This Out-Of-Pocket-Limit only applies to usual and customary covered medical expenses.]

[{\$100 - \$5,000} Excess Provision]

[We will not pay any Hospital, surgical or medical expenses under any provisions, in excess of {\$100- \$5,000} to the extent that those same expenses are paid or payable under any of the following plans: Individual, Group, Blanket Franchise Plans, or Union Welfare Plans, including Group Blue Cross and Blue Shield. However, if such expenses remain unpaid after such plans have paid their benefits in full, we will pay such remaining expenses, which are covered under this policy. The same terms of the Policy will apply in paying such remaining expenses.]

1. [This provision does not apply if total eligible expenses are {\$100 - \$5,000} or less.] [The Policyholder shall pay 100% of the premium.]
2. [The Student Accident Coverage provides coverage on an Excess basis. Under this plan, the [first] {\$100 - \$5,000} of covered charges are paid without regard to any other applicable coverage that may be in effect. After the [first] {\$100 - \$5,000} in covered charges are paid, expenses which are not covered by your other personal or group insurance are eligible for coverage under this plan up to the Policy limit.]

This provision will apply even though the plans named above contain coordination of benefits, non-duplication of benefits or similar provisions.

[This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.]

Maximum Benefit Limitations

Maximum Benefit Limitations are stated in the Schedule of Benefits.

[ACCIDENTAL DEATH,] [DISMEMBERMENT,] [AND] [LOSS OF SIGHT] BENEFIT]

[Upon receipt of due proof that an Insured sustains a Loss, we will pay the benefit shown in the Schedule of Benefits provided:

- (1) such Loss occurs within {100 - 365} days after the date of the Accident causing such Loss; and
- (2) such Injury results directly and independently of all other causes; and
- (3) such Injury is sustained while the Insured is covered under this policy.

"Loss" under this benefit shall mean with regard to hands and feet, actual severance above the wrist or ankle joint; with regard to sight, the entire and irrevocable loss thereof.

If the Insured sustains more than one of the losses, shown in the Schedule of Benefits, in one Accident, the total amount payable is the largest specified which applies to the Loss sustained as shown in the Schedule of Benefits.

[Any benefit payable under this provision is in addition to any benefit otherwise payable under this Policy. Benefit amounts are stated in the Schedule of Benefits.]

All other conditions and provisions remain unchanged.]

[DENTAL COVERAGE BENEFIT]

[Upon receipt of due proof that an Insured incurred expenses for dental treatment performed as a result of Injury, covered by this Policy, we will pay the benefit shown in the Schedule of Benefits.

This benefit covers Accidents occurring during covered School Sponsored and Supervised Activities. This includes all athletics and all forms of transportation. Coverage begins on the effective date of the Master Policy and ends on the termination date of the Master Policy.

The Insured must be treated by a legally qualified dentist, who is not a family member. The initial treatment must be rendered within {20 - 60 days} from the date of Injury. We will then pay the [Usual and Customary Charge][Actual Charge] for necessary dental treatment which is incurred within {one - five years} from the date of Injury. This benefit covers the treatment of sound and natural teeth as well as capped or crowned teeth.]

[{\$100 - \$5,000} Excess Provision

If there is other valid coverage providing benefits for the same Loss, benefits in excess of {\$100-\$5,000} shall be paid first by the other coverage. The balance of unpaid eligible dental expenses will then be paid under this Policy.

[This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.]]

[Additional][Exclusions

Benefits will not be paid for:

- [1. Conditions which are not caused by Injury;]
- [2. Re-injury or complications of a condition which existed prior to the Accident; or]
- [3. Orthodontics and damage to or Loss of dentures or bridges.]]

All other conditions and provisions remain unchanged.]

[VOLUNTARY PARTICIPATION DENTAL COVERAGE BENEFIT]

[Upon receipt of due proof that an Insured incurred expenses for dental treatment performed as a result of Injury, covered by this Policy, we will pay the benefit as shown below.

This benefit covers Accidents occurring anytime and anywhere. This includes all athletics and all forms of transportation. Coverage begins on {October 1} if the Voluntary Participation enrollment envelope is returned to the School in {September}. Enrollments received after {September 30} will become effective on the {1st} of the month following receipt by the company. Coverage terminates on {September 30} of the following year.

The Insured shall receive necessary treatment and services commencing within {60 – 180} days of the date of Accident, by a legally licensed and practicing dentist, the Company will pay up to [Usual and Customary Charge][Actual Charge] {\$500 - \$1,000} for each treatment and service, subject to the following:

- a) The maximum amount payable for any one Accident resulting in treatment or repair by a dentist of dentures, braces, caps, crowns, fillings, bridges, prosthetic, or orthodontic devices, or any other artificial dental device shall not exceed {\$200 - \$500}.
- b) The maximum amount payable for any one Accident resulting in treatment by a dentist of sound, natural teeth shall not exceed {\$2,000 - \$5,000}.
- c) In no event shall the Company's payment exceed the [Usual and Customary Charge][Actual Charge] normally made by a dentist for necessary treatment actually rendered during the {26 - 52} week period immediately following the date of the Accident.
- d) Upon proper certification by a dentist that treatment cannot be performed during the {26 - 52} weeks immediately following the date of Accident, the Company will pay up to {\$50 - \$100}, the maximum allowance for such deferred treatment.

[Additional][Exclusions

Benefits will not be paid for:

- 1) [Conditions which are not caused by Injury;]
- 2) [Expenses resulting from accidental Injury occurring while this Benefit is not in force;]
- 3) [Injury caused by war or act of war, or while in the armed forces;]
- 4) [Existing, pre-existing, or congenital dental injuries or defects, which are not caused by Injury sustained within this Benefit term.]]

All other conditions and provisions remain unchanged.]

[STUDENT ACCIDENT ONLY 24-HOUR COVERAGE BENEFIT]

[Each person who pays the required 24-Hour Premium is insured on a 24-hour per day basis. Coverage is subject to all Exclusions and Limitations shown in the Policy.]

[\$100 - \$5,000] Excess Provision]

[We will not pay any Hospital, surgical, or medical expenses under any provisions to the extent that those same expenses are paid or payable under any of the following plans: Individual, Group, Blanket or Franchise Plans, Union Welfare Plans, including Group Blue Cross and Blue Shield. However, if such expenses remain unpaid after such plans have paid their benefits in full, we will pay such remaining expenses, which are covered under this policy. The same terms of the Policy will apply in paying such remaining expenses.

This provision will apply even though the plans named above contain coordination of benefit, non-duplication of benefits or similar provisions.]

[This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.]

[STUDENT DISABILITY BENEFIT

[The student (or Eligible Person) for whom the school pays the Student Disability premium is covered for Injury as a result of an Eligible Person becoming disabled. For the purposes of this benefit, the following definitions have been added:

BRAIN DEATH means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain even though the heart is still beating.

COMA means a profound state of complete and total unconsciousness from which the Insured, through powerful stimulation, is not likely to be aroused. This condition must be diagnosed and regularly treated by a Physician.

COVERED SCHOOL ACTIVITY under this benefit means [(1) regularly planned school [interscholastic athletics] [functions which are organized and scheduled solely by the school] on or off school premises[, including games, scrimmages and practice sessions involving: [interscholastic athletes,] band members, cheerleaders, majorettes, and student managers]; [and [(2) all school sponsored and supervised activities, such as classes, school plays, concerts or field trips].

DISABILITY under this benefit means Coma, Brain Death or Paralysis of two or more limbs, caused by an Injury while participating in a Covered School Activity. Such disability must continue for six months and be diagnosed by a Physician as being permanent.

ELIGIBLE PERSON under this benefit means a Student of the policyholder for whom the appropriate disability premium has been paid and who participates in the Covered School Activity.

INJURY under this benefit means coma, brain death or paralysis of two or more limbs, caused while participating in a Covered School Activity. Such Injury must continue for six months and be diagnosed by a Physician as being permanent.

PARALYSIS/PARALYZED means the complete inability to move one or more limbs as a result of neurological damage. This condition must be diagnosed and regularly treated by a Physician.

Benefits are as follows:

If an Eligible Person sustains an Injury while participating in a Covered School Activity and while this Policy is in force, becomes disabled, as defined herein, the Company will pay an initial Disability Benefit of {\$10,000 - \$50,000} beginning in the {6th - 12th} month of Disability. Subsequently, followed by additional monthly Disability Benefit payments of {\$1,000 - \$5,000} until {age 65} or until the {\$50,000 - \$1,000,000} Maximum Disability Benefit, has been reached subject to the following:

- 1) The Injury results in Coma, Brain Death, or Paralysis of two or more limbs;
- 2) The Disability continues for {six months}; and
- 3) A Physician has diagnosed the Disability as being permanent.

Benefits are paid directly to the Eligible Person, or parent or guardian of the Eligible Person, if a minor.

[Additional][Exclusions

Benefits will not be paid for:

- 1) [Conditions which are not caused by an Injury;]
- 2) [Expenses resulting from an Injury occurring while this Benefit is not in force;]
- 3) [Injury not sustained during a Covered School Activity;]
- 4) [Intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane;]
- 5) **[Gas inhalation or poison voluntarily taken, administered or inhaled;**
- 6) [Injury caused by war or act of war, or while in the armed forces;]
- 7) [Existing or pre-existing injuries or defects, which are not caused by an Injury sustained while this Benefit is in force.]]

All other conditions and provisions remain unchanged.]]

EFFECTIVE DATE, POLICY TERM AND POLICY TERMINATION

This Policy takes effect and terminates on the dates stated in the Schedule of Benefits of this Policy. Coverage is afforded for the term or terms designated. All periods of insurance shall begin and end at 12:01 P.M. Standard Time, at the address of the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL VOLUNTARY PARTICIPATION
STUDENT ACCIDENT ONLY INSURANCE**

The insurance of each Insured who applies for insurance on or before the effective date hereof shall take effect on the effective date of this Policy. Insurance of any Insured applying for insurance after the effective date hereof shall take effect on the date of application and receipt of premium.

The Insured's coverage will end on the following date:

- [1. School Time Plan - The termination date shown in the Schedule of Benefits.]
- [2. 24-Hour Plan - The opening day of the next academic year.]

PRE-EXISTING CONDITIONS

No benefits will be payable [in excess of {\$100}] for the Insured's pre-existing conditions. They are defined as an Injury sustained for which the Insured [noticed symptoms or] was medically diagnosed, treated (including medication), or advised by a Physician within the {six - twelve months} immediately prior to his Effective Date of Coverage under the Policy.

Covered Medical Expenses resulting from a pre-existing condition will not be covered unless {six - twelve} consecutive months have elapsed during which no medical treatment or advice is given by a Physician for such condition.]

[This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.]

MAXIMUM LIABILITY

In no event shall the Company's maximum liability exceed the total amount of {\$5,000 - \$5,000,000} in the aggregate, as a result of any one covered Injury and further provided that no liability shall exist on the part of the Company for any expense incurred after {52 weeks - lifetime} immediately following the date of such Injury.]

[This provision will apply even though the plans named above contain coordination of benefits, non-duplication of benefits or similar provisions.]

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER In administering this Policy all Insureds must be treated equally. We will rely on your acts.

CLERICAL ERROR Clerical errors or delays in keeping records for this Policy will not deny insurance which would otherwise have been granted; nor extend insurance which otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES This Policy, your application, and any endorsements or other attachments is the entire contract between you and us. Any statement you or the Insured makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between you and us. No change in this Policy will be effective until it is approved by one of our executive officers. This approval must be noted on or attached to this Policy. No agent or other person has authority to change this Policy or to waive any of its terms.

INCONTESTABILITY After this Policy has been in force for two years, it can only be contested for non-payment of premiums. No statement made by an Insured can be used in a contest after his insurance has been in force for two years during his lifetime. No statement an Insured makes can be used in a contest unless it is in writing and signed by him.

NONPARTICIPATING This Policy is a nonparticipating Policy; it does not share in our surplus.

PREMIUM DUE DATE: The premium is due on this Policy's Effective Date. Premiums are payable at the Company's Home Office, Baltimore, Maryland or to an authorized representative.

RECORDS Sufficient records must be maintained to show the names of all Insureds; the dates they became insured; and any such other information required to administer this Policy.

RIGHT TO TERMINATE You or we may end this Policy at any time by giving written notice to the other party [thirty-one (31) days] prior to the effective date of termination. You must notify all Insureds of such Policy termination.

CLAIM PROVISIONS

BENEFICIARY The Insured's beneficiary is the person or persons designated by the Insured in writing and entered in the insurance records for this Policy. The Insured may change such designation by written notice to the Policyholder.

A beneficiary change becomes effective only when the new designation is entered in such records. But the change then relates back to take effect as of the date the Insured signed the notice, even though the Insured may not be living when the entry is made. Any payment or other action by the Company before the entry is made will not prejudice the Company.

An Insured does not need the consent of the beneficiary to make a beneficiary change.

[CLAIM FORMS When we receive notice of claim, the Insured will be sent forms to file proof of loss. If the forms are not sent within {15 days} after we receive notice, then the Insured will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.]

FACILITY OF PAYMENT If the beneficiary is a minor, or for any other reason is not capable of giving, a valid release for any payment due, we may, at our option, and until claim is made by the duly appointed guardian of the beneficiary, make such payment to:

- (a) any relative of the beneficiary by blood or marriage; or
- (b) any other person or institution which appears to us to have assumed custody and principal support of the beneficiary.

Such payment(s) may not exceed {\$20 - \$100 per month}. They must be made for the sole benefit of the beneficiary.

If, with respect to any amount of insurance payable at the Insured's death,

- (1) no beneficiary designation is in effect, or
- (2) no designated beneficiary is then living,

We may pay, at our option, such amount to the Insured's estate or to any one or more of the following who survive the Insured:

- (A) wife or husband;
- (B) children, including adopted or stepchildren;
- (C) mother or father;
- (D) brothers or sisters.

Our liability shall be fully discharged to the extent of payment made under this provision.

LEGAL ACTIONS No legal action may be brought to recover against this Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of this Policy is less than allowed by the laws of the state where the Insured lives, the limit is extended to meet the minimum time allowed by such law.

NOTICE OF CLAIM We must be given written notice of claim within {20 - 60} days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the Insured's name and enough information to identify him. Notice may be mailed to our Claims Administrator.

PAYMENT OF CLAIMS Claims for benefits provided by this Policy will be paid as soon as written proof is received.

All benefits of this Policy, except those for Loss of life, are payable to the Insured. In the event the Insured is a minor, we will pay any amount otherwise payable to him as Insured to a relative or beneficiary or other person we deem entitled to the payment. [Benefits for Loss of life under Accidental Death and Dismemberment Insurance are payable to the Insured's Beneficiary or to one or more other persons under terms of the Facility of Payment provision.] Payment so made will satisfy our duty to make payment as to the limited benefit paid. We do not assume any responsibility for the validity of any assignment.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Insured examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

PROOF OF LOSS Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason if it is shown that written proof of the loss was given as soon as reasonably possible, but in no event more than one year after the date of loss.

[RIGHT OF SUBROGATION [We will be fully and completely subrogated to the rights of a Covered Person against parties who may be liable to provide indemnity or make a contribution with respect to any matter that is the subject of a claim under the Policy.]

The Covered Person further agrees to cooperate fully with us in seeking such indemnity or contribution including, where appropriate, when we are instituting proceedings at its own expense against such parties in the name of the Covered Person. The Covered Person further agrees that the Company will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the Injury, the person's agent or a court having jurisdiction in the matter.]

RIGHT TO RECOVERY If payments for claims exceed the Maximum amount payable under any benefit provisions or riders of this Policy, we have the right to recover the excess of such payments.

Monumental Life Insurance Company

HOME OFFICE: CEDAR RAPIDS, IOWA

POLICY ENDORSEMENT

Policyholder: {ABC School} **[Policy Effective Date:** {January 1, 2010}]
Policy Number: {XXXXXXXX} **[Policy Anniversary:** {January 1, 2010}]
Endorsement Effective Date: {January 1, 2011}

In consideration of the [initial] [return] [additional] premium [paid] [in the amount of {\$1.00 - \$1,000,000}], it is hereby understood and agreed that policy number {MLSA2100GBP} has been amended as follows:

[An Additional Policy Term is added to the Policy.

This Additional Policy Term is: {January 1, 2010 through December 31, 2010}]

[Amend Policyholders address: _____]

[Effective {January 1, 2010} the Policy would cover the following groups:

1. [All School Sponsored and Supervised Activities including all interscholastic sports,]
2. [All School Sponsored and Supervised Activities including [senior high school] tackle football,]
3. [All School Sponsored and Supervised Activities excluding all interscholastic sports,]
4. [All School Sponsored and Supervised Activities including all interscholastic sports except tackle football,]
5. [Interscholastic sports including [senior high school] tackle football,]
6. [Interscholastic sports except tackle football,]
7. [Interscholastic [senior high school] tackle football only,]
8. [Voluntary participation school time and 24-hour plans including all interscholastic sports except tackle football,]
9. [Voluntary participation school time and 24-hour plans excluding all interscholastic sports,]
10. [Voluntary student dental plan,]
11. [Specifically named student group(s), team(s), club(s), event(s), trip(s), as specified by the Policyholder].]

This endorsement attached to and hereby made part of policy number {MLSA2100GBP} is issued to {Policyholder} by Monumental Life Insurance Company.

Nothing herein contained shall vary, alter or extend any provision or condition of the policy other than as above stated.

Authorized Agent

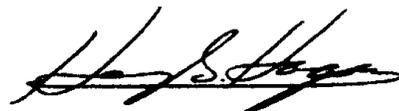
Policyholder

Not valid unless countersigned by a duly authorized agent of Monumental Life Insurance Company and the Policyholder.

Except as provided herein, this Endorsement is subject to all the terms and provisions and limitations of the Policy to which it is attached.



Secretary



President



- 1. NAME OF SCHOOL OR DISTRICT _____
- 2. ADDRESS _____
Street City State Zip Code
- 3. Grade Structure. Please Check One:
 - K-12 School District
 - Regional High School District
 - Vocational School District
 - Individual High School or Jr. H.S.]
 - Other _____]
 - Nursery School]
 - Individual Elementary School]
 - K-6 District]
 - K-8 District]
- 4. Estimated Enrollment:
Students _____
Teachers _____
Total _____
- 5. Check Blocks to indicate coverage desired: _____

[[• VOLUNTARY PARTICIPATION PLANS----STUDENT INSURANCE]

[(See Page 1 for Premium Rates)]

- PLAN A - [\$500,000] Comprehensive Plan Excluding all interscholastic sports
[Including {\$5,000 - \$25,000} Optional Student Dental Insurance]
[Including {\$5,000 - \$20,000} Optional Student Term Life Insurance]
- PLAN B - [\$500,000] Comprehensive Plan Including all sports except football]]
[Including {\$5,000 - \$25,000} Optional Student Dental Insurance]
[Including {\$5,000 - \$20,000} Optional Student Term Life Insurance]]

[[• COMPULSORY ENROLLMENT PLANS----STUDENT INSURANCE]

[Premiums to be paid by the School----Minimum premium [\$500.00]]

[Maximum Benefit Desired: \$1,000,000][\$5,000,000] [Other (specify)_____]]

[Basis of Payment: Non Excess] [Partial Excess][Full Excess] [Primary Excess]]

[Benefit Period {1 year – lifetime}]

[Interscholastic Sports: Exclude All Sports] [Include All Sports Except Football] [Include All Sports and Football]

[Benefit Level (See Brochure): Plan 1] [Plan 2] [Plan 3] [Plan 4] [Customized (attach schedule)]

[Deductibles {\$0.00 - \$500,000} and Special Instructions _____]

[Coinsurance {10%-50% } and Special Instructions _____]

[[• FOOTBALL AND SPORTS INSURANCE PLANS]

[Coverage Desired: Football] [All Other Sports] [Band, Cheerleaders, etc.]]

[Maximum Benefit Desired: \$1,000,000] [\$5,000,000] [Other (specify)]]

[Basis of Payments for Basic Plan: Full Excess] [Primary Excess] [Primary]]

[Benefit Period {1 year – lifetime}]

[Benefit Level (See Brochure): Plan 1] [Plan 2] [Plan 3] [Plan 4] [Customized (attach schedule)]

[Deductibles {\$0.00 - \$500,000} and Special Instructions _____]

[Coinsurance {10%-50% } and Special Instructions _____]

6. INSTRUCTIONS FOR SHIPPING ENROLLMENT ENVELOPES AND SUPPLIES:

(Please Check One):

DELIVERY ADDRESS

Package all supplies in BULK]

Same as No. 2 above

Package separately for EACH SCHOOL]

Other _____

(list of addresses and enrollment for each school must be enclosed)

Signature and Title of Person Completing This Form

Telephone

Date

Mail the White Copy of

This Application Today to:

(Keep {Pink} Copy for your record.)

Bollinger
Insurance Solutions

101 JFK Parkway
Short Hills, N.J. 07078
Telephone (973) 467-0444

<i>SERFF Tracking Number:</i>	<i>AEGX-126458195</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monumental Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44597</i>
<i>Company Tracking Number:</i>	<i>GH AR0047655F01</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Student Health</i>		
<i>Project Name/Number:</i>	<i>Student Health/GH AR0047655F01</i>		

Supporting Document Schedules

		Item Status:	Status
			Date:
Satisfied - Item:	Application	Approved-Closed	01/26/2010
Comments:	Master Application attached on Forms Tab.		

		Item Status:	Status
			Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/26/2010
Comments:			
Attachment:	AR - READABILITY CERTIFICATION.PDF		

		Item Status:	Status
			Date:
Satisfied - Item:	Explanation Of Variability	Approved-Closed	01/26/2010
Comments:			
Attachment:	Explanation Of Variability.PDF		

		Item Status:	Status
			Date:
Satisfied - Item:	AR - SERFF ONLY - FILING AT A GLANCE	Approved-Closed	01/26/2010
Comments:			
Attachment:	AR - SERFF ONLY - FILING AT A GLANCE.PDF		

		Item Status:	Status
			Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	01/26/2010

SERFF Tracking Number: AEGX-126458195 State: Arkansas
Filing Company: Monumental Life Insurance Company State Tracking Number: 44597
Company Tracking Number: GH AR0047655F01
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Student Health
Project Name/Number: Student Health/GH AR0047655F01

Comments:

Attachment:

AR - NAIC TRANSMITTAL DOCUMENT.PDF

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	01/26/2010

Comments:

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	01/26/2010

Comments:

Attachment:

Cover Letter.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Monumental Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
MLSA2100GBP	40
MLSA2101GBER	40 when combined with Policy
MLSA2100GBMA	56.7

Signed: 
Name: Stephen M. Baloga
Title: Assistant Actuary
Date: 1/15/10

**EXPLANATION OF VARIABILITY
GROUP BLANKET STUDENT ACCIDENT INSURANCE POLICY - MLSA2100GBP**

[] = included or excluded

Benefits and provisions enclosed in square brackets [] are optional. Unless a bracketed benefit and/or provision is addressed in this Explanation of Variability, it will be included or excluded. Where a bracketed benefit and/or provision is addressed on this Explanation of Variability, the conditions under which it will be included or excluded are described herein.

{ } = a range

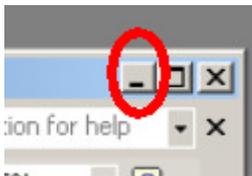
Benefits and provisions enclosed in parentheses { } are variable. These benefits and/or provisions will always be included, and the information contained within the parentheses defines the range of variability that is permitted under the policy. Where no range is set forth (e.g., phone numbers), up-to-date information will be included.



DO NOT open this form until the filing has been successfully sent to SERFF. The way to verify that the submission was successful is that there is a SERFF Filing ID and the SERFF Status has changed to Submitted. If you open this form prior to receiving the SERFF Filing ID and SERFF Status of Submitted, this form WILL NOT auto populate with all the required information.

To ensure the form properly auto populates, please take the following steps:

1. Minimize the form by clicking the "minimize button" in the upper right corner of the Word document.



2. "Edit Filing Form" window will then appear on your desktop.



3. Click the "Cancel" button.
4. Close the Word document. You will be returned to the "Filing Forms" tab.
5. Wait until you receive the SERFF Filing ID and the SERFF status advances to Submitted for the filing. When you open this form again, this form will be re-generated with the proper information auto populated. **If you close this form before clicking the "Cancel" button in the "Edit Filing Form" window, this form will not properly auto populate again.**

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
-----------	----------------------------------	----------

2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Monumental Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA		468	66281	52-0419790	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Mary J. DiMarcantonio, ALHC 520 Park Avenue Baltimore MD 21201	800-233-4624 Ext. 5263	410-209-5910	mdimarcantonio@aegonusa.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
---------------------------------	--

6. Company Tracking Number	GH AR0047655F01
-----------------------------------	-----------------

7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
-----------	--

8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise Group: <input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input checked="" type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
------------------	--

9. Type of Insurance	H02G Group Health - Accident Only
-----------------------------	-----------------------------------

10. Product Coding Matrix Filing Code	H02G.000 Health - Accident Only
--	---------------------------------

11. Submitted Documents	<input type="checkbox"/> FORMS <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
--------------------------------	---

12.	Filing Submission Date	1/14/10
13.	Filing Fee (If required)	Amount <u>\$50.00</u> Check Date <u>EFT</u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>EFT</u>
14.	Date of Domiciliary Approval	Pending
15.	Filing Description:	
<p>The attached forms are being filed for your review and approval. These are new forms and do not replace any existing form.</p> <p>This Blanket Student Accident Insurance Policy will be issued direct in your state and will be offered to School Boards to provide accident coverage to students in grades kindergarten through 12. The items within the [] brackets indicate language that will either be included or deleted from the forms. The items within the { } brackets indicate language that will change.</p> <p>These forms offer plans with a coinsurance percentage and/or an out of pocket maximum option. The coinsurance percentage and out of pocket maximum option are bracketed and will only be used with our Compulsory plans.</p> <p>All SERFF filing submission requirements have been met.</p> <p>We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions or need any additional information, please do not hesitate to contact me. Thank you in advance for your help and attention to this matter.</p>		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
Print Name <u>Mary J. DiMarcantonio, ALHC</u> Title <u>Product Filing & Compliance Analyst</u>		
Signature <u></u> Date <u>1/15/10</u>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GH AR0047655F01
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Blanket Student Accident Only Insurance Policy	MLSA2100GBP	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Policy Endorsement	MLSA2101GBER	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Master Application	MLSA2100GBMA	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	



Administrative Office | 520 Park Avenue | Baltimore | Maryland 21201-4500

January 15, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: Monumental Life Insurance Company
Blanket Student Accident Only Policy
Company Filing #: GH AR0047655F01
Form MLSA2100GBP, et al. (see attached List of Forms)
NAIC #: 468-66281 FEIN #: 52-0419790

Dear Commissioner Bradford:

The above referenced forms are being filed for your review and approval. These are new forms and do not replace any existing form.

This Blanket Student Accident Insurance Policy will be issued direct in your state and will be offered to School Boards to provide accident coverage to students in grades kindergarten through 12. The items within the [] brackets indicate language that will either be included or deleted from the forms. The items within the { } brackets indicate language that will change.

These forms offer plans with a coinsurance percentage and/or an out of pocket maximum option. The coinsurance percentage and out of pocket maximum option are bracketed and will only be used with our Compulsory plans.

All SERFF filing submission requirements have been met.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions or need any additional information, please do not hesitate to contact me. Thank you in advance for your help and attention to this matter.

Sincerely,

A handwritten signature in black ink that reads 'Mary J. DiMarcantonio'.

Mary J. DiMarcantonio, ALHC
Product Filing and Compliance Analyst
1-800-233-4624 Ext. 5263
mdimarcantonio@aegonusa.com

LIST OF POLICY FORMS

MLSA2100GBP et al.

FORM DESCRIPTION

FORM NUMBER

Blanket Student Accident
Insurance Policy
Policy Endorsement
Master Application

MLSA2100GBP
MLSA2100GBER
MLSA2100GBMA

<i>SERFF Tracking Number:</i>	<i>AEGX-126458195</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monumental Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44597</i>
<i>Company Tracking Number:</i>	<i>GH AR0047655F01</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Student Health</i>		
<i>Project Name/Number:</i>	<i>Student Health/GH AR0047655F01</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/15/2010	Form	Master Application	06/16/2010	MLSA2100GBMA.PDF (Superseded)
01/15/2010	Form	Policy Endorsement	02/22/2010	MLSA2101GBER.PDF (Superseded)



1. NAME OF SCHOOL OR DISTRICT _____

2. ADDRESS _____

3. Grade Structure. Please Check One:
Street City State Zip Code

- K-12 School District
- Regional High School District
- Vocational School District
- Individual High School or Jr. H.S.]
- Other _____]
- Nursery School]
- Individual Elementary School]
- K-6 District]
- K-8 District]

4. Estimated Enrollment:
Students _____
Teachers _____
Total _____

5. Check Blocks to indicate coverage desired: _____

- VOLUNTARY PARTICIPATION PLANS----STUDENT INSURANCE]**
[(See Page 1 for Premium Rates)]
 - PLAN A - [\$500,000] Comprehensive Plan Excluding all interscholastic sports
[Including {\$5,000 - \$25,000} Optional Student Dental Insurance]
[Including {\$5,000 - \$20,000} Optional Student Term Life Insurance]
 - PLAN B - [\$500,000] Comprehensive Plan Including all sports except football]]
[Including {\$5,000 - \$25,000} Optional Student Dental Insurance]
[Including {\$5,000 - \$20,000} Optional Student Term Life Insurance]]

- COMPULSORY ENROLLMENT PLANS----STUDENT INSURANCE]**
[Premiums to be paid by the School----Minimum premium [\$500.00]]
[Maximum Benefit Desired: [\$1,000,000][\$5,000,000] [Other (specify)_____]]
[Basis of Payment: [Non Excess] [Partial Excess][Full Excess] [Primary Excess]]
[Benefit Period {1 year – lifetime}]
[Interscholastic Sports: [Exclude All Sports] [Include All Sports Except Football] [Include All Sports and Football]]
[Benefit Level (See Brochure): [Plan 1] [Plan 2] [Plan 3] [Plan 4] [Customized (attach schedule)]
[Deductibles {\$0.00 - \$500,000} and Special Instructions _____]
[Coinsurance {10%-50% } and Special Instructions _____]

Formatted

- FOOTBALL AND SPORTS INSURANCE PLANS]**
[Coverage Desired: [Football] [All Other Sports] [Band, Cheerleaders, etc.]]
[Maximum Benefit Desired: [\$1,000,000] [\$5,000,000] [Other (specify)]]
[Basis of Payments for Basic Plan: [Full Excess] [Primary Excess] [Primary]]
[Benefit Period {1 year – lifetime}]
[Benefit Level (See Brochure): [Plan 1] [Plan 2] [Plan 3] [Plan 4] [Customized (attach schedule)]
[Deductibles {\$0.00 - \$500,000} and Special Instructions _____]
[Coinsurance {10%-50% } and Special Instructions _____]

6. INSTRUCTIONS FOR SHIPPING ENROLLMENT ENVELOPES AND SUPPLIES:
(Please Check One): DELIVERY ADDRESS
 Package all supplies in BULK] • Same as No. 2 above
 Package separately for EACH SCHOOL] • Other _____
(list of addresses and enrollment for _____
each school must be enclosed) _____

Signature and Title of Person Completing This Form

Telephone

Date

Mail the White Copy of
This Application Today to:
(Keep {Pink} Copy for your record.)

Bollinger
Insurance **Solutions**

101 JFK Parkway
Short Hills, N.J. 07078
Telephone (973) 467-0444

SA2100GBMA

Monumental Life Insurance Company

HOME OFFICE: CEDAR RAPIDS, IOWA

POLICY ENDORSEMENT

In consideration of the [initial] [return] [additional] premium [paid] [in the amount of [\$11.00]], it is hereby understood and agreed that policy number [MLSA2100GBP] has been amended as follows:

[Amend Insured's address as follows: _____]

[Effective [1/01/10] – add [[15] Youth Baseball Participants]]

[Effective [1/01/10] – remove [[15] Youth Baseball Participants]]

This endorsement attached to and hereby made part of policy number [MLSA2100GBP] is issued to [ABC Youth Recreation Department] by Monumental Life Insurance Company.

Nothing herein contained shall vary, alter or extend any provision or condition of the policy other than as above stated.

Effective Date: [1/01/10] Termination Date: [12/31/10] Master Policy No.: [MLSA2100GBP]

Issued to: [ABC Youth Recreation]

Authorized Agent

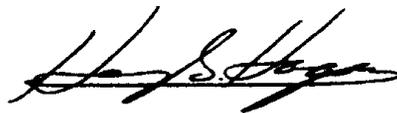
Policyholder

Not valid unless countersigned by a duly authorized agent of Monumental Life Insurance Company and the Policyholder.

Except as provided herein, this Endorsement is subject to all the terms and provisions and limitations of the Policy to which it is attached.



Secretary



President