Protect your child with Student Accident Insurance or Health Insurance

School is not a spectator sport. From hopping and skipping to blocking and tackling, our commitment to protecting kids starts as early as kindergarten.

That's why we're here!

Online Enrollment—Secured Accident & Health Plans
Coverage can be purchased any time throughout the year.
Remember to visit our website for faster enrollment.
Checks, money orders, or credit cards accepted.
DO NOT SEND CASH

Serviced by: **K&K Insurance Group, Inc.**
Phone: 855-742-3135
Underwritten by: **Nationwide Life Insurance Company**

2011-2012 School Year

www.studentinsurance-kk.com

Review Your Benefits:

Maximum Benefits Paid As Specified Below

Medically Necessary and Reasonable Charges are based on the 75th percentile.
STUDENT HEALTH PLAN ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury or Sickness up to the $50,000 Maximum Benefit as specified below for each Injury or Sickness after the $50 Deductible.
ACCIDENT ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

Compare and Choose	Low Option Accident Only	High Option Accident Only	Student Health Plan
Maximum Benefit:	$25,000 (For Each Injury)	$25,000 (For Each Injury)	$50,000 (For Each Injury or Sickness)
Deductible:	$0	$0	$50
Inpatient			
Room & Board:	Up to $150 per day Semi-private or private room rate	80% of Reasonable Charges Semi-private or private room rate	$950 maximum per day
Hospital Miscellaneous:	$600 maximum per day	$1,200 maximum per day	Included under Room & Board
Registered Nurse:	75% of Reasonable Charges	100% of Reasonable Charges	80% of Reasonable Charges
Physician's Visits: *(Benefits are limited to one visit per day and do not apply when related to surgery)*	$40 first day/$30 each subsequent day	$60 first day/$40 each subsequent day	$50 first day/$30 each subsequent day
Outpatient			
Day Surgery Miscellaneous:	$1,000 maximum	$1,200 per day	$950 maximum
Physician's Visits: *(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)*	$40 first day/$30 each subsequent day	$60 first day/$40 each subsequent day	Maximum visits per condition: 5 Maximum We will pay per visit: **$50** *One (1) annual physical Per Policy Year*
Outpatient Physical Therapy: *(Benefits are limited to one visit per day)*	$30 first day/$20 each subsequent day 5 days maximum	$60 first day/$40 each subsequent day 5 days maximum	Paid under Physician's Visits
Emergency Room Services: *(Use of room and supplies; treatment must be rendered within 72 hours from the time of the injury)*	$150 maximum	$300 maximum	$200 per condition maximum
X-Rays:	$200 maximum	$600 maximum	$350 maximum per condition
Diagnostic Imaging Services:	$300 maximum	$600 maximum	$500 combined maximum per condition
Laboratory:	$50 maximum	$300 maximum	$200 maximum per condition
Prescription Drugs:	$75 maximum	$200 maximum	No Benefits
Orthopedic Braces & Appliances:	$75 maximum	$140 maximum	Included under Durable Medical Equipment
Inpatient and/or Outpatient			
Surgeon's Fees: *(No more than one procedure through the same incision will be paid)*	$1,000 maximum	$1,200 maximum	$2,500 maximum
Anesthetist:	20% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Assistant Surgeon:	20% of Surgery Allowance	25% of Surgery Allowance	No Benefits
Ambulance:	$300 maximum	$800 maximum	$250 per Injury or per sickness maximum
Consultant:	$200 maximum	$400 maximum	No Benefits
Dental Treatment due to Injury to Teeth: *(For Injury to sound, natural teeth only treatment must be received within 90 days of Injury)*	$10,000 maximum per policy term if extended dental option purchased. $200 per tooth	$10,000 maximum per policy term if extended dental option purchased. $500 per tooth	$200 per tooth maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a Covered Injury:	100% of Reasonable Charges	100% of Reasonable Charges	No Benefits
Durable Medical Equipment:	No Benefits	No Benefits	$100 per Injury or per sickness maximum
Maternity:	No Benefits	No Benefits	Paid as any other Sickness
Complication of Pregnancy:	No Benefits	No Benefits	Paid as any other Sickness

Expenses for the following are not covered (except as mandated): Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

Details of these benefits may be found in the Master Policy on file at the School District. ***NOTE:*** *This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control the payment of benefits.*

Choose Your Coverage Plan: *One-Time Payment For Accident Coverage*

24-Hour Accident (Students & Employees)

- Around-the-clock/anywhere in the world.
- Before, during and after school
- Weekends, vacation and all summer including summer school
- School sponsored and extracurricular sports excluding High School Football

	With Extended Dental	Without Extended Dental
Low Option	$69.00	$62.00
High Option	$102.00	$95.00

24-Hour Accident (Summer Only Coverage)

Summer begins on the first day after the school year ends.
Summer ends the first day of the next school year.

	With Extended Dental	Without Extended Dental
Low Option	$23.00	$16.00
High Option	$32.00	$25.00

At-School Accident (Students & Employees)

- During the regular school term, on school premises while school is in session
- Direct and uninterrupted travel to and from home and scheduled classes
- School Sponsored and supervised sports excluding High School Football
- Travel to and from school sponsored and supervised sports while in a school approved vehicle

	With Extended Dental	Without Extended Dental
Low Option	$22.00	$15.00
High Option	$29.00	$22.00

Extended Dental (Accident Only)

- Supplemental coverage extended to students with At-School, 24-Hour or Football Coverage – Limited to Covered Person's policy effective dates and accident only coverage option selected
- Replaces standard dental coverage with coverage of 80% of Reasonable Charges to a maximum limit of $10,000 per injury

High School Football

- Play or practice or regularly scheduled football
- Consult your Athletic Department for enrollment instructions

	With Extended Dental	Without Extended Dental
Low Option	$113.00	$106.00
High Option	$172.00	$165.00

Spring Only Rates

For new players who participate in spring training and not already insured under Football Coverage.
Sports seasons are defined by your state high school athletic association.

	With Extended Dental	Without Extended Dental
Low Option	$49.00	$42.00
High Option	$73.00	$66.00

PLEASE NOTE - FOR COVERAGE PLANS LISTED ABOVE

Coverage Effective Date: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.

Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year.

All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible.
Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

Student Health Plan

- $588 per quarter, or $2,352* annual (Per Policy Year) *cannot be purchased after September 30th.
- Covers sickness & accidents which happen anytime, 24-hours a day while your student is insured under this plan (excluding interscholastic sports).
- Benefits are payable according to the benefit schedule up to $50,000 after the $50 deductible has been met per policy year.

Policy Exclusions and Limitations for Health Plan Coverage

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

Pre existing are not covered for the first (12) months following the Covered Person's Effective Date of Coverage under the Policy.
This limitation will not apply if, during the period immediately preceding the Covered Person's Effective Date under this Policy, the Covered Person was covered under prior Creditable Coverage for twelve (12) consecutive months. Prior Creditable Coverage for less than twelve (12) months will be credited towards satisfying the Pre-existing limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for Coverage within sixty-three (63) days of termination of his or her prior Coverage.

1. Eyeglasses, contact lenses, including but not limited to routine eye refractions, eye exams (except as in the case of Injury). Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein;
2. Hearing Screenings or hearing examinations or hearing aids and the fitting or repairing of hearing aids; except in the case of Accident or Injury
3. Vaccinations, inoculations and preventive shots: a) required for travel; b) required for employment; c) provided as wellness or prevention
4. Treatment (other than surgery) of chronic Conditions of the foot including, but not limited to, weak or fallen arches, flat or pronated foot ,subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and orthotics;
5. Cosmetic surgery, Plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections);
6. Sexual reassignment surgery or any treatment of gender identity disorders;
7. Treatment, service, or supply which is not Medically Necessary as determined by Nationwide Life Insurance for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Person's Attending Doctor or dentist.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
9. Custodial Care;
10. Treatment on or to the Teeth or gums (except as provided herein);
11. Injury sustained while (a) participating in any interscholastic sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or Conditioning program for such sport, contest, or competition;
12. For Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle and/or off –road four wheeled motorized vehicles, personal watercraft, parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, speed contests, or bungee jumping;
13. Injury occurring in consequence of riding or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline;
14. Travel in or upon motor vehicles not primarily designed and licensed for use on public streets or highways;
15. Reproductive/Infertility services including but not limited to: fertility tests, infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; artificial insemination; premarital examination; impotence, organic or otherwise; sterilization or sterilization reversal; vasectomy;
16. Routine newborn, infant care, well baby nursery and related Doctor charges, including circumcision (except as otherwise provided herein)
17. Elective termination of pregnancy including the morning after pill, plan B;
18. Hospital Confinement or any other services or treatment that You or Your Dependent(s) are not legally obligated to pay or for which no charge is made.
19. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment;
20. Any services of a Doctor, Nurse, or Health Care Practitioner who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
21. Services received before the Insured's Effective Date or during an Inpatient stay that began before the Insured's Effective Date.
22. Services received after the Insured's Coverage ends.
23. Drugs and medicines when not confined in a Hospital as an Inpatient;
24. Vitamins, minerals, food supplements, herbs, herbal Formulas, or home remedies; except as herein provided.
25. Addictions such as nicotine addiction, caffeine addiction and non-chemicals addictions such as gambling, sexual, spending, shopping, working and religious; and codependency;
26. Testing for learning disabilities or other educational purposes including, but not limited to school placement or progress, psychological or intelligence testing;
27. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy;
28. Treatments which do not meet the national standards for mental health professional practice; telephonic consultation, methadone maintenance or treatment; and facilities or homes that provide twenty-four (24) hour non-medical residential care or day care.
29. Injuries sustained as a result of suicide or any attempt at suicide, including drug overdose or intentional/unintentional self-inflicted Injury or any attempt at intentional/unintentional self-inflicted Injury;
30. Services for the treatment of any Injury or Illness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense;
31. Any and all over the counter smoking cessation and treatment of nicotine addiction products;
32. Obesity treatment: Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to: Gastric or intestinal bypasses; Gastric balloons; Stomach stapling; Wiring of the jaw; Panniculectomy; Appetite suppressants; Surgery for removal of excess skin or fat;
33. War or any act of war, declared or undeclared; or while in the armed forces of any country;
34. Nutrition counseling services, except for treatment of diabetes, genetic counseling and genetic studies;
35. General fitness, exercise programs, health club memberships and weight loss programs. Exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Doctor's prescription;
36. Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogeniec stem cell transplants, including non-human organs or bone marrow; Anything caused by, contributed to, or resulting from an organ transplant, including complications thereof;
37. Treatment received outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital;
38. TMJ
39. For any injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Doctor;
40. Any benefit not listed in this Policy.
41. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.

Policy Exclusions and Limitations for Accident Only Coverages

The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced.

We will not pay Benefits for:

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders:

We will not pay Benefits for:

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
5. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
6. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
7. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
8. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
9. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
10. Expenses Incurred for supervision of an anesthetist.
11. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
12. Expenses Incurred for subsequent repairs and replacement of prosthetic devices.

Accidental Death & Specific Loss Benefits:

Life	$10,000
Both arms or both legs	$10,000
Both hands and both feet	$10,000
One arm and one leg	$10,000
One hand and one foot	$10,000
Either both hands or both feet	$10,000
Speech and hearing in both ears	$10,000
The sight of both eyes	$10,000
The sight of one eye and either one hand or one foot	$10,000
Either one arm or one leg	$7,500
Either one hand or one foot	$5,000
Speech or hearing in both ears	$5,000
Sight of one eye	$5,000
Hearing in one ear	$2,500
Both the thumb and index finger of one hand	$2,500

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

Enroll online at:
www.StudentInsurance-kk.com, or by mail

1. Complete and detach the enrollment form.
2. Make check or money order payable to Nationwide Life Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Insert check, credit card information or money order in the attached envelope.
5. Mail envelope to: K&K Insurance Group,
   P.O. Box 2338
   Fort Wayne, IN 46801-2338
6. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
7. Keep this brochure for future reference. Individual policies will not be sent to you.
8. For Student Health Plan, no premium notices will be sent. Initial enrollment deadline is September 30th for Annual Premium Payment (Per Policy Year).

Facts about the Policy

1. WHO IS ELIGIBLE: students of the policyholder who make the required premium contribution for the coverage selected are eligible. Student status continues after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy on file with the school district is a non-renewable policy.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
5. COVERAGE TERMINATION DATE: Accident Coverage will terminate on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year.
   All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible.
   Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

Health

Coverage will terminate at 12:01 A.M. standard time at the Covered Person's residence on the earliest of:

- The termination date of the Policy;
- The date the insured ceases to be an Eligible Person;
- The last day of the term of Coverage for which Premium is paid;
- The date a Covered Person enters full time active military service. We will refund any unearned pro-rata Premium with respect to such person.

6. LATE ENROLLMENT: There is no premium reduction for any individual who enrolls late in the year.

Administered by:

K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338

Health Plan Definitions:

Pre-existing Condition A Sickness or Injury (a) for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) months immediately prior to an Insured's Effective Date of Coverage; or (b) a pregnancy existing on the Insured's Effective Date of Coverage.

Sickness Illness, disease, pregnancy and Complications of Pregnancy. All related Conditions and recurrent symptoms of the same or a similar Condition will be considered the same Sickness.

Injury: Bodily injury due to a sudden, unforeseeable, external event which: Results solely, directly independently of disease, bodily infirmity or any other causes; Occurs after the Covered Person's Effective Date of Coverage; Occurs while Coverage is in force. All injuries sustained in any one Accident, including all related Conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident Only Definitions:

Injury A bodily injury which is:

1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:

1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered as one Injury.

Cut out card and retain for your records

Student Insurance Card

Student's Name_____

If premium has been paid, the student whose name appears above has been insured under a Policy issued to:

School District:_____

Accident Only Coverage: ❑ 24-HOUR ❑ 24-HOUR (Summer Only Coverage)

❑ AT-SCHOOL ❑ FOOTBALL ❑ FOOTBALL (Spring Only) ❑ EXTENDED DENTAL

Health Plan Coverage: ❑ INJURY AND SICKNESS

Paid by Check #_____ Amount Paid:_____ Date Paid:_____

Underwritten by: Nationwide Life Insurance Company

Claims Questions: K&K Insurance Group, Inc.

1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917

Enroll online for quicker service www.StudentInsurance-kk.com, or complete and mail this form

Enrollment Form (School Year 2011-2012)

Student's Last Name:_____

Student's First Name:_____

Student's Middle Name:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Name of School District (required):_____

Name of School:_____

Grade Level: ❑ Pre-K/Headstart ❑ Kindergarten/Elementary ❑ Middle School ❑ High School/Above

Signature of Parent or Guardian:_____

Date:_____ Email Address:_____

Student Insurance --- Check Your Selection:

Accident Only Coverage Plans	Low Option	High Option
24-HOUR with Extended Dental	$69.00 ❑	$102.00 ❑
24-HOUR without Extended Dental	$62.00 ❑	$95.00 ❑
Summer Only 24-HOUR with Extended Dental	$23.00 ❑	$32.00 ❑
Summer Only 24-HOUR without Extended Dental	$16.00 ❑	$25.00 ❑
AT-SCHOOL with Extended Dental	$22.00 ❑	$29.00 ❑
AT-SCHOOL without Extended Dental	$15.00 ❑	$22.00 ❑
HIGH SCHOOL FOOTBALL		
with Extended Dental	$113.00 ❑	$172.00 ❑
without Extended Dental	$106.00 ❑	$165.00 ❑
*For New Players		
*Spring Football with Extended Dental	$49.00 ❑	$73.00 ❑
*Spring Football without Extended Dental	$42.00 ❑	$66.00 ❑

STUDENT HEALTH PLAN			
	• **100% Plan**	❑ $2,352.00*	Per Policy Year
	• **30% / 70% Plan**	❑ $705.60*	$1,646.40 Due in 30 days
	• **25% + 3 Plan**	❑ $588.00*	$588.00 Due in 30 days/60 days/90 days

* *Premium amount due to bind coverage based on payment option.*

COMPANY USE ONLY

Check No._____

Amount Received_____

Date Received_____

Enclose check for total payment payable to:

Nationwide Life Insurance Company.

TOTAL ENCLOSED: $_____

Complete this section only if you wish to pay with a Credit Card

1726 (AZ/FL_MB_ENG_05/11)

Full Name on Card:

First Name:_____ MI:_____ Last Name:_____

Billing Address *(if different than above)*

Street #_____ Address_____ Apt #_____

City:_____ State:_____ Zip:_____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date: Month: ☐☐ Year: ☐☐☐☐

Cardholder signature:_____

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)