Day Care Accident Medical Insurance

- Day Cares
- Kindergartens
- Pre-Schools
- Nursery Schools
- Etc.

Francis L. Dean & Associates, LLC

FDL

The Leader in Sports, Leisure and Entertainment Insurance

Day Care Accident Medical Insurance

Who Is Covered

All enrollees in the covered activity. Policyholder staff may be included.

Covered Activity

All activities sponsored and supervised by the Policyholder, including travel with a group in connection with such activities, and travel directly and without delay to or from the enrollee's home or residence and the site of such activities.

Medical Expense Benefit

If the Covered Person incurs eligible expenses as the direct result of a covered injury and independent of all other causes, the Company will pay the charges incurred for such expense within 365 days, beginning on the date of accident. Payment will be made for eligible expenses in excess of the applicable Deductible Amount, not to exceed the $25,000.00 Maximum Medical Benefit.

The first such expense must be incurred within 90 days after the date of the accident.

"Eligible expense" means charges for the following necessary treatment and service, not to exceed the usual and customary charges in the area where provided.

- Medical and surgical care by a physician
- Radiology (X-rays)
- Prescription drugs and medicines
- Hospital care and service in semi-private accommodations, or as an outpatient
- Ambulance service from the scene of the accident to the nearest hospital
- Orthopedic appliances necessary to promote healing
- Dental treatment of sound natural teeth, Dental injury max. is $250.00 per tooth, $1,000.00 maximum

If Excess coverage is selected, this plan does not cover treatment or service for which benefits are payable or service is available under any other insurance or medical service plan available to the Covered Person. Primary coverage pays benefits under the plan without offset for other insurance (except Workers' Compensation).

Accidental Death and Dismemberment Benefit

If a covered injury results in any of the losses specified below within 365 days after the date of the accident, the Company will pay the applicable amount:

- Full Principal Sum for loss of life, double dismemberment or quadriplegia
- Full Principal Sum for loss of sight, loss of hearing, or loss of speech that is irrecoverable by natural, surgical or artificial means.
- 50% of the Principal Sum for loss of one arm, one leg, one hand, or one foot. Loss of hand or foot means complete severance above the wrist or ankle joint.
- 50% of the Principal Sum for paraplegia or hemiplegia
- 50% of the Principal Sum as a monthly benefit for Coma
- 25% of the Principal Sum for loss of index finger and thumb of same hand or four fingers of the same hand

We will not pay more than the $10,000.00 Principal Sum for this Benefit for all losses due to the same accident.

Exclusions and Limitations

This plan does not cover any loss to or resulting from:

- Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
- War or any act of war, declared or undeclared.
- Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
- Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
- Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
- Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
- Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
- Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
- Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
- Treatment of a hernia, Osgood- Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
- Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
- Eyeglasses, contact lenses, hearing aids.
- Aircraft travel, except as a fare paying customer.

Day Care Accident Medical Insurance

Part I Proposed Policyholder

Please print or type

a. **Full Legal Name of Proposed Policyholder** _____

b. **Mailing Address** _____
Street City State Zip

c. **Contact Person** _____

Phone Number _____ **Email Address** _____

d. **Requested Effective Date** _____ **Termination Date** _____

**Policy will become effective on the Requested Effective Date if (a) all required information is provided and (b) the Company has received the initial premium on or before that date.*

e. **Type of Program** ☐ Day Care ☐ Pre-School ☐ Nursey School ☐ Kindergarten ☐ Other _____
(check any that apply)

Part II Plan of Benefits and Premium Calculation

Accidental Death Benefit	Maximum Medical Benefit	Deductible Amount	12 Months Coverage		9 Months Coverage		3 Months Coverage	
			Primary Plan Rate Per Person	Excess Plan Rate Per Person	Primary Plan Rate Per Person	Excess Plan Rate Per Person	Primary Plan Rate Per Person	Excess Plan Rate Per Person
$10,000.00	**$25,000.00**	**$0.00**	$6.45	$4.20	$5.20	$3.90	$2.65	$2.00
$10,000.00	**$25,000.00**	**$25.00**	$5.25	$3.35	$4.25	$3.15	$2.15	$1.65
$10,000.00	**$25,000.00**	**$50.00**	$4.30	$2.95	$3.50	$2.70	$1.85	$1.40
$10,000.00	**$25,000.00**	**$100.00**	$3.85	$2.50	$3.25	$2.30	$1.50	$1.10

a. **Policy Term (choose one)** ☐ 12 Months ☐ 9 Months ☐ 3 Months

Scope of Coverage (choose one) ☐ Primary ☐ Excess

Deductible (choose one) ☐ $0.00 ☐ $25.00 ☐ $50.00 ☐ $100.00

b. **Premium Calculation**

Number of Enrollees	Number of Staff (optional)	Total	Rate Per Person	Total Policy Premium
	+	=	x	=

Fully Earned Minimum Premium is $300.00

Minimum Premium is Fully Earned Upon Policy Inception

Part III Payment

Choose one of the following options. Please initial your choice:

☐ Enclosed is my payment for the total premium. ☐ Check ☐ ACH (see below) ☐ Credit Card (see below)

Account Billing Address _____
Street City State Zip

Phone Number _____ E-mail Address _____

☐ Please bill my: ☐ Checking Account ☐ Savings Account

Name on Account _____

Bank Name _____

Bank City/State _____

Routing Number _____

Account Number _____

There is no convenience fee when you choose the ACH option.

☐ Please charge my: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Card # _____

Exp. Date (mm/yyyy) _____

Security Code _____

A Convenience Fee of 3% will be added to Credit Card Transactions.

There is no convenience fee when you choose the ACH option or pay via check.

Part IV Acknowledgements and Signatures

a. This summary of coverage and exclusions is no substitute for reading the entire policy. To receive an entire policy, contact the program administrator.

b. **Fraud Warning** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material there to, commits a fraudulent insurance act, which may be a crime.

c. **Applicant's Acknowledgement** I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of the Company will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of the Company, and (d) only those persons eligible under the terms of an issued policy will be insured.

Signed for the Proposed Policyholder _____

Signed by Licensed Agent _____

Agency Name and License Number _____

Date _____

Agent Phone Number _____

Agent Email Address _____

Agency Mailing Address _____

Francis L. Dean & Associates, LLC
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United States Fire Insurance Company, "A" rated by A.M. Best Company. A member of the Crum & Forster group of companies.