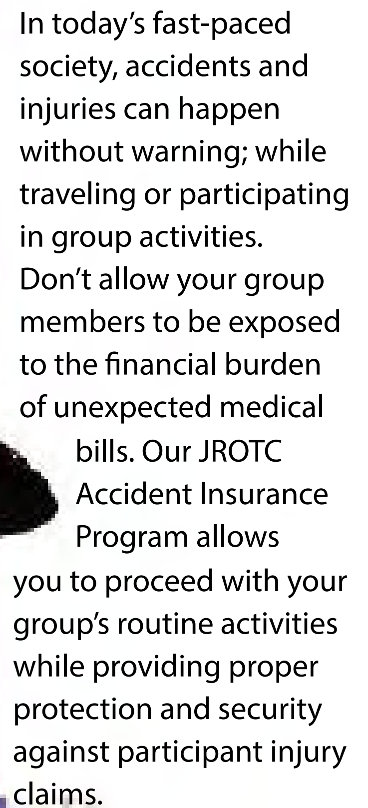
JROTC Group Accident *Insurance*



In today's fast-paced society, accidents and injuries can happen without warning; while traveling or participating in group activities. Don't allow your group members to be exposed to the financial burden of unexpected medical bills. Our JROTC Accident Insurance Program allows you to proceed with your group's routine activities while providing proper protection and security against participant injury claims.

- **Trips/Outings**
- **Camps**
- **Military Balls**
- **Drill Meets**
- **Parades**
- **Etc.**

Francis L. Dean & Associates, LLC

FDL

The Leader in Sports, Leisure and Entertainment Insurance

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 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.

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.

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.
- Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.

This information is a brief description of the important benefits and features of the Accident Medical Insurance provided by US Fire Insurance Company. This description is neither an insurance policy or contract nor an offer to enter into any form of insurance contract. You should not rely on the terms of this description but, rather, should review the policy terms in detail prior to purchasing this or any insurance policy. Any policy we offer to issue will be subject to the laws of the jurisdiction in which it is issued.

Plan of Benefits

AD&D Benefit	Max. Med. Expence	Deductible Amount	Short-Term Rate Per Person	Annual Rate Per Person
$1,000.00	**$5,000.00**	**$0.00**	$.42	$3.15
$1,000.00	**$5,000.00**	**$25.00**	$.37	$2.80
$1,000.00	**$5,000.00**	**$50.00**	$.21	$2.60
$2,500.00	**$10,000.00**	**$0.00**	$.53	$3.75
$2,500.00	**$10,000.00**	**$25.00**	$.48	$3.40
$2,500.00	**$10,000.00**	**$50.00**	$.32	$3.15
$5,000.00	**$15,000.00**	**$0.00**	$.57	$4.55
$5,000.00	**$15,000.00**	**$25.00**	$.50	$4.20
$5,000.00	**$15,000.00**	**$50.00**	$.35	$3.95
$5,000.00	**$25,000.00**	**$0.00**	$.63	$5.50
$5,000.00	**$25,000.00**	**$25.00**	$.59	$5.05
$5,000.00	**$25,000.00**	**$50.00**	$.42	$4.80

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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.*

Part II Premium Calculation

a. **Plan of Benefits**

Policy to Cover

☐ All Participants of the Policyholder ☐ All Participants and Staff of the Policyholder

Accidental Death & Dismemberment Principle Sum $ ______________

Maximum Medical Expense Benefit $ ______________

Deductible Amount $ ______________

Excess coverage is provided

b. **Premium Calculation**

Check one: ☐ Short-term ☐ Annual

Number of participants ________ + **Number of staff** ________ = **Total Eligibles** ________

Total Eligibles ________ **x** **Number of Days** ________ **x** **Daily Rate of $** ________ = **$** ________

(or) **Total Eligibles** ________ **x** **Annual Rate of $** ________ = **$** ________

Fully Earned Minimum Premium is $200.00
Minimum Premium is Fully Earned Upon Policy Inception

Part III Payment

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

☐ Enclosed is my check for the total premium.

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

For Premiums less than $1,000.00, a $10.00 convenience fee will be added.
For Premiums $1,000.00 and higher, a convenience fee equal to 2.5% of the premium will be added.

Name on Card ______________________________

Cardholder Billing Address ______________________________

____

Card # ______________________________ Exp. Date (mm/yyyy) ______________

Security Code ______________

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

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www.fdean.com

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