## STUDENT ATHLETIC/ACCIDENT INSURANCE

1) The District has a Student Athletic Accident Insurance policy that provides benefits for injuries sustained during Athletic participation. The policy also includes Band, Cheerleading, Majorettes, Physical Education classes and Field Trips. This plan of insurance is secondary/supplemental to any health insurance you may have. As such, all expenses must be submitted to your own insurance first.

   When you file a claim a Claim Form should be partially completed by the School, and then given to you for further completion. You must inform the providers of treatment that there is secondary insurance coverage through the District and give them the claim office's name, mailing address, telephone number and policy number all of which can be found at the top of the Claim Form. The completed Claim Form should then be sent to the claims office.

   Note: The Athletic Accident Insurance policy benefits are limited and therefore may not provide 100% coverage.

2) Parents may also purchase additional insurance at their own cost described in the attached brochure. This Voluntary insurance can provide benefits for injuries that your child may sustain during the school day, or even out of school, depending upon the plan that you purchase. Enrollment in the Voluntary insurance is done directly with the insurance carrier either online or by completing and mailing the enrollment form included in the attached brochure.

Included in this brochure are:

A) The Student Athletic Accident Claim Form that is to be used, if needed, to file a claim for an injury.

B) The optional Voluntary insurance information and application that parents have the option of purchasing at their own expense.

# How to file a Medical Claim

**(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)**
**Attached is a claim form for your accident policy.**
**Please forward claims and questions to the following address:**

**90 Degree Benefits**
**PO Box 6540**
**Harrisburg, Pa 17112**
**Ph: 1-800-427-9308**
**Fax: (717) 652-8328**
**Email: Student.Insurance@90degreebenefits.com**

**Step 1: The Participating Organization (NOT the Parent, Claimant or Agent) should:**

- Fully answer each item in Part I, The Participating Organization Statement.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

**Step 2: The Parent/Guardian or Adult Claimant Should:**

- Fully answer each item in Part II, including the claimant's personal information, parent's information, along with other insurance information.
- In order to ensure we receive complete claim information, we require providers to submit standardized itemized bills (called "**UB04**" for hospital charges and/or a "**CMS-1500**" for physician charges).
- Providers may bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). **We are Primary over State provided Insurance (i.e. all Medicaid programs) and Non-active Duty TRICARE.**
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment, or zero balance information) claim payment is sent directly to the medical providers.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

**Helpful information for submitting claims**

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will be sent back to injured party, to complete missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- The claimant must seek treatment, resulting in a medical expense, within 90 days of the injury. Contact our office for verification.
- Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

**Step 3: Submit the Completed Notice of Claim (Claim Form) via either by mail, fax, or email listed above. Please note: if sending information via email, it is only used to receive incoming information. Any questions about claims please call our office.**

1. Please Fully Complete This Form
2. See Filing Instructions Attached
3. Mail To

90 Degree Benefits
PO Box 6540
Harrisburg, PA 17112
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: Student.Insurance@90degreebenefits.com

AXIS

## PART I - PARTICIPATING ORGANIZATION STATEMENT

| Policy Number: | Organization Name: | Event, Activity, or Sport: |
|---|---|---|
| KAMB-168111 | Wachusett Regional School District, MA | |

| Claimant's Name (Injured Person) | The Injured Person Was A: ☐ Participant ☐ Staff Member ☐ Other | Date and Time Of Accident: |
|---|---|---|
| Place Where Accident Occurred: | Type of Injury: (Indicate Part Of Body Injured - e.g. broken arm, etc.) | |

Describe How Accident Occurred - Provide All Possible Details:

| Dental Claims | Indicate Which Teeth Were Involved: | Describe Condition of Injured Teeth Prior To Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial |
|---|---|---|

Did Accident (Check Yes or No for Each of The Following):

| | | | |
|---|---|---|---|
| A. | During A Participating Organization Sponsored & Supervised, or Sanctioned Activity? | ☐ YES | ☐ No |
| B. | On Activity Premises: | ☐ YES | ☐ No |
| C. | While Traveling Directly and Uninterruptedly to Or Form the Activity? | ☐ YES | ☐ No |
| D. | During A Participating Organization Practice or Competition? | ☐ YES | ☐ No |
| E. | Did Injury Result in Death: | ☐ YES | ☐ No |

| Signature of Participating Organization Representative: | Name & Title of Participating Organization Representative: | Date: |
|---|---|---|
| | | |

## PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

| Best Contact Number (Included Area Code): | Social Security Number (Of Injured): | Gender (Of Injured): ☐ M ☐ F | Date of Birth (Of Injured): |
|---|---|---|---|
| | | | |

Address (in which information should be mailed to):

Do you/spouse/parent have medical/health care, or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

## PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

**SIGNATURE:** _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

**SIGNATURE:** _____ **DATE:** _____

## Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** 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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

B

# UP TO $1,000,000 STUDENT ACCIDENT MEDICAL INSURANCE PROTECTION

ADMINISTERED BY:

Lefebvre Insurance, LLC
901 Pleasant Street #1413
Attleboro, MA 02703
(800) 451-9668

## 2024-2025

Underwritten By:
AXIS Insurance Company

## 24 HOUR ACCIDENT COVERAGE

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12 . . . . . $50.00

## SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees. Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12. . . . . $8.00

## CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). The claim form must be filed with the Company within 90 days after the accident. Covered Excess Expenses must be incurred within 90 days from the date of accident. Related expenses are eligible for up to two years from the date of accident. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

**Direct All Questions and Correspondence To:**

LEFEBVRE INSURANCE, LLC
901 Pleasant Street #1413
Attleboro, MA 02703
(800) 451-9668

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. DO NOT SEND CASH.

## OPTIONAL $50,000.00 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means Replacement of caps, crowns, dentures, and orthodontic appliances, (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x- ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the Usual & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Covered Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. If the Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12. . . . . $8.00

This coverage **cannot** be purchased without School Time or 24 Hour coverage.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within 180 days of the Covered Accident

| Covered Loss | Benefit Amount |
|---|---|
| Loss of Life | $5,000 |
| Loss of Two or More Hands or Feet | $20,000 |
| Loss of Sight of Both Eyes | $20,000 |
| Loss of One Hand or Foot and Sight in One Eye | $20,000 |
| Loss of One Hand or Foot | $10,000 |
| Loss of Sight in One Eye | $10,000 |
| Loss of Thumb and Index Finger of the same Hand | $10,000 |
| Loss of all Four Fingers of the Same Hand | $10,000 |
| **Exposure and Disappearance** | **Included** |

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of thumb or index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

## Effective & Termination Date

Coverage becomes effective on the date the Application and Premium are received by the school. Once effective, coverage continues until the first day of school in the following year or until the policy with the school expires, whichever occurs first.

# ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 ACCIDENT MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 104 weeks from the date of the Injury.

**MAXIMUM BENEFITS**

**Hospital Services:**

Daily Room & Board (Semi-private) . . . . . Up to $800/day
Intensive Care Room & Board . . . . . .Usual & Customary
(Not to exceed 7 days)

**Miscellaneous Services:**

During Hospital Confinement or when surgery is performed . . . . . Up to $800/day
Emergency Room out-patient: when Hospital Confinement is not required . . . . . Usual & Customary

**Doctor's Services:**

Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of . . . . . $150 unit value
Anesthesia: (including administration) and assistant surgeon: (% of surgical allowance) . . . . . 25%
Doctor Visits other than for Physiotherapy or similar treatment when no surgery benefit is paid . . . . . Usual & Customary
Consultants (when required by attending physician for confirmation or determining a diagnosis, but not for treatment) and second opinion: . . . . . Usual & Customary

**Laboratory & X-Ray Services:**

Other than Dental and including fee for interpretation and/or reading of X-Ray
X-ray when not Hospital Confined X-ray . Usual & Customary
Lab . . . . . Usual & Customary
MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading . . . . . Up to $800

**Additional Services:**

Physiotherapy or similar treatment:
In-Hospital . . . . . Usual & Customary
Out of Hospital . . . . . Up to $1,500
Chiropractic Services (in or out of hospital) . . . . Up to $500
Registered Nurse (in or out of hospital) . Usual & Customary
Ambulance to initial treatment facility . . Usual & Customary
Orthopedic Appliances:
In-hospital . . . . . Usual & Customary
Out of Hospital . . . . . Up to $1,000
Outpatient Drugs & Medication:
Administered by a Doctor . . . . . Usual & Customary
Eyeglasses, Contact Lenses and Hearing Aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered Injury . . . . . Up to $650

**Dental Services:**

For treatment, repair or replacement of Injured natural teeth, includes initial braces when required for treatment of a covered Injury, as well as examinations, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma . . . . . Up to $750/tooth

**FULL EXCESS COVERAGE**

Benefits are payable for Medically Necessary covered expenses that are in excess of amounts payable under any Other Health Care Plan and are subject to the applicable Total Maximum for all Accident Medical Benefits. If the Insured is not covered by any Other Health Care Plan providing Accident Medical Benefits, the excess provision shall not apply, and benefits are payable to the total Maximum for all Accident Medical Benefits as shown in your Master Insurance Application.

**EXCLUSIONS AND LIMITATIONS**

**Exclusions:** The policy does not cover any loss incurred as a result of:

**Limitation for Motor Vehicle Accidents**

Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed $5,000.

**Excluded Expenses**

For the purposes of this Accident Medical Benefit, the following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses; and
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

**COMMON EXCLUSIONS:**

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault; or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. parachuting;
7. travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or indirectly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. injuries compensable under Workers' Compensation law or any similar law;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including traveling to and from games and practice, unless specifically provided for;
13. participation in any sports activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal School hours, including snowboarding skiing and ice hockey (does not apply if 24-Hour Coverage is selected);
14. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;
    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
    d. the Insured Person.

**Disclosure**

THIS IS A BLANKET ACCIDENT ONLY POLICY.

The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.

US insurance coverage is underwritten by AXIS Insurance Company under group policy form series number [BACC-001-0909-MA]. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES

# TO FILE A CLAIM:

1. Use attached claim form
2. Fill out all necessary information
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

**90 Degree Benefits**
PO Box 6540
Harrisburg, Pa 17112

**phone:** 1-800-427-9308 **fax:** (717) 652-8328 **email:** Student.Insurance@90degreebenefits.com

Proof of Loss is required within 90 days from the date of the Accident. You have ONE year from the time Proof of Loss would have been required to file a claim. Claims submitted past this period will not be considered for payment under the policy.

## ENROLLMENT FORM CHECKLIST

DID YOU:

- ☐ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)
- ☐ Check the appropriate box(s) for the coverage you have selected.
- ☐ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

## FOR QUESTIONS, INQUIRIES, AND INFORMATION CONTACT:

Lefebvre Insurance, LLC
901 Pleasant Street #1413
Attleboro, MA 02703
(800) 451-9668

DO NOT SEND CASH

# ENROLLMENT FORM

Please Print 2024-2025

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY STATE ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

**FRAUD WARNING:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

## School Year Rate – ✓ CHECK YOUR SELECTION

| COVERAGE PLANS | PREMIUMS |
|---|---|
| 24-Hour – Including Extended Dental | ☐ $58.00 |
| 24 Hour Only | ☐ $50.00 |
| School Time – Including Extended Dental | ☐ $16.00 |
| School Time Only | ☐ $8.00 |

Make checks payable to AXIS Insurance Company

## HOW TO ENROLL

1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to AXIS Insurance Company for the correct amount.
3. Mail envelope to Lefebvre Insurance, LLC. - 901 Pleasant Street #1413, Attleboro, MA 02703. Your cancelled check or money order stub will be your receipt and confirmation of payment. (Please write the student's name and school name on your check.)