VOLUNTARY FOOTBALL ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 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 52 weeks from the date of the Injury.

MAXIMUM BENEFITS

Hospital Services:

Daily Room & Board (Semi-Private) Avg. Semi-Private Rate Up to $500/day

Intensive Care Room & Board . . . . . $750/Day not to exceed 7 days

Miscellaneous Services:

During Hospital confinement or when surgery is performed . . . . . 75% of Usual & Customary to $10,000

Emergency Room outpatient: when Hospital Confinement is not required $250.00

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 . . . . . $140.00 unit value Maximum $10,000

Anesthesia: (including administration) and assistant surgeon: % of surgical allowance. 30%

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: $100.00

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 $500.00
Lab $500.00

MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/r reading $500.00

Additional Services:

Physiotherapy or similar treatment:
In-Hospital $500.00
Out of Hospital $500.00

Chiropractic Services (in or out of hospital) $100.00

Registered Nurse (in or out of hospital) . . . . . Usual & Customary

Ambulance to initial treatment facility . . . . . Usual & Customary

Orthopedic Appliances:
In-hospital $500.00
Out of Hospital $500.00

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 $300.00

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 examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma . . . . . $400 / tooth
Maximum $12,800

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

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 the Benefit Limit shown in the *Schedule of Benefits*.

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;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
5. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).
6. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).

In no event will the Company's total payments for the Insured Person or exceed the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.
Other Exclusions that apply to this Accident Medical Benefit are in the Common Exclusions Section.

Common Exclusions:

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. Illness or medical condition arising out of, suicide, or any attempt while sane or insane;
2. Death, injury incurred, or disease contracted, to which a contributing cause was the Insured Person's commission or attempt to commit a felony or which occurs while the Insured Person is engaged in an illegal occupation;
3. Illness, treatment or medical condition arising out of the commission of or active participation in a riot or insurrection;
4. Illness, treatment or medical condition arising out of the 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. 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 non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. Death, injury incurred, or disease contracted while the Insured Person is intoxicated or under the influence of any narcotic, or hallucinogenic drug, unless prescribed or taken under the direction of a Physician;
9. injuries compensable under Workers' Compensation law or any similar law;
10. 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.

DO NOT SEND CASH ▲ **CUT ON DOTTED LINE** ▲

PLEASE PRINT

FOOTBALL ENROLLMENT FORM

_____
STUDENT'S LAST NAME

_____
STUDENT'S FIRST NAME MIDDLE INITIAL

___ ___ ___ - ___ ___ - ___ ___ ___ ___ _____
STUDENT'S SOCIAL SECURITY # BIRTHDATE (MO/DAY/YR)

GRADE _____ PHONE ( ) _____

ADDRESS _____

_____
CITY STATE ZIP CODE

_____
SCHOOL DISTRICT

_____
SCHOOL NAME

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

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

CHECK YOUR SELECTION

COVERAGE	PREMIUM
Interscholastic Football	**____ $80.00**

_____

Make Check Payable to:

AXIS INSURANCE COMPANY

ACCIDENTAL DEATH & DISMEMBERMENT

When injury shall result in any one of the following losses within 180 days from the date of accident, the company will pay for loss of:

Life	$5,000
Both hands or both feet or the entire sight of both eyes	$20,000
One Hand and One Foot	$20,000
Either One Hand or One Foot and the Entire Sight of One Eye	$20,000
One Hand or One Foot or the entire sight of one eye	$10,000

"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.

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.

Disclosure: US insurance coverage is underwritten by AXIS Insurance Company. 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. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. 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 for the under the Patient Protection and Affordable Care Act.

Effective & Termination Date

Covers only senior high interscholastic tackle football, grades 9-12. Coverage begins when official practice is allowed or when payment for the coverage is received, whichever is later, and ends on the last day of the football season.

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). You will receive a claim form which must be filed with the Company within 90 days after the accident. Covered Excess Expenses incurred within one year from the accident will be considered. 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
850 Franklin Street, Wrentham, MA 02093
(800)451-9668

How to Enroll

1. Fill out the enrollment form and enclose the form along with a check or money order made payable to AXIS Insurance Company shown for the correct amount.
2. Mail envelope to Lefebvre Insurance, LLC. – 850 Franklin Street – Wrentham, MA 02093. 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.)
3. Retain this portion for your records and reference.

▲ CUT ON DOTTED LINE ▲