VOLUNTARY FOOTBALL ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 IN MEDICAL COVERAGE

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 is stated below. Benefits are payable for treatment rendered up to 52 weeks after the date of injury.

MAXIMUM BENEFITS

Hospital Service:

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

Intensive Care Room & Board . . . . .Up to $750/day

Miscellaneous Services:

During Hospital confinement
or when surgery is performed . . . . 75% of Usual & Customary up to $10,000.00

Emergency Room outpatient when
Hospital confinement is not required $250.00

Doctor's Services:

Surgery, including pre and post
operative care . . . . .Usual & Customary up to $10,000.00

Anesthesia & Assistant Surgeons. . . . . 30% of surgical allowance

Doctor visits other than for
Physiotherapy or similar treatment
When no surgery benefit is paid . . . . Usual & Customary

Consultants and Second Opinions $100.00

Laboratory & X-ray Services:

Other than dental, and including fee
for interpretation and/or reading when
not hospital confined $500.00
Laboratory services $500.00
MRIs, CAT Scans, Laser Treatments $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 or Licensed Nurse . . . . Usual & Customary
Ambulance to initial treatment facility . . . . Usual & Customary
Orthopedic Appliances:
In-Hospital $500.00
Out-of-Hospital $500.00
Outpatient drugs or medication . . . . 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 of gingivitis resulting from trauma . . . . $400/tooth to maximum of $12,800

FULL EXCESS COVERAGE

Benefits are payable for covered expenses that are not recoverable from another insurance plan providing medical benefits to the applicable medical maximum. If the insured is not covered by another plan providing medical benefits, the excess provision shall not apply, and benefits are payable to the accident medical maximum described.

CONDITIONS

The accident must be reported immediately to a school official. You will receive a claim form which must be completed and filed with the Company within 90 days after the accident. The first physician's visit must be within 90 days after the accident. Covered excess expenses incurred within one year from the accident will be considered.

EXCLUSIONS: This policy does not cover:

1. Service or treatment rendered by a physician, nurse or any other person who is: (a) employed or retained by you; or (b) who is the Insured or a member of his/her family;
2. Charges which (a) the Insured would not have to pay if he/she did not have insurance; or (b) are in excess of Usual and Customary Expenses;
3. Suicide or any attempt at suicide, or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;
4. That part of medical expenses payable by any automobile insurance policy without regard to fault (does not apply in any state that prohibits such limitation);
5. Fainting, congenital conditions, birth defects, complications or aggravation of pre-existing conditions, Osgood-Schlatter's Disease or similar conditions;
6. Sickness, disease, or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning;
7. Any injury resulting from the participation in or practice for non-school sponsored tackle football;
8. The insured being under the influence of drugs or intoxicants, unless taken under the advice of a physician;
9. Expenses incurred in connection with plastic or cosmetic surgery or procedures unless required by an injury which occurred while the Insured was covered;
10. Eyeglasses, contact lenses, eye refraction or prescriptions therefore, except for the usual, reasonable and customary charge for the replacement of broken eyeglasses, broken frames, or broken lenses resulting from a covered accident. Routine refraction and routine eye examinations are not covered under this policy;
11. Overuse symptoms, bursitis, tendinitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjuries of the aggravation thereof;
12. Benefits will not be duplicated if an Insured is covered under more than one Student Accident plan of coverage issued by us.

(The above is a list of exclusions applicable to the Voluntary Football Accident Insurance. Some exclusions stated in the master policy have been omitted as they are not applicable to the Voluntary Football Accident Insurance)

▼ **CUT ON DOTTED LINE** ▼

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DO NOT SEND CASH

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 (Parent/Guardian/or Adult Applicant)

I acknowledge that I have read, understand, and agree to the conditions of this coverage.

CHECK YOUR SELECTION

COVERAGE	PREMIUM
Interscholastic Football	____ **$80.00**

Make Check Payable to:
ACE AMERICAN INSURANCE

ME-VFB

ACCIDENTAL DEATH & DISMEMBERMENT

If injury to the insured results in any one of the following losses within 180 days from the date of accident, the Company will pay for the 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
Thumb and index finger of same hand . . $5,000

"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 and 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.

LIMITATIONS

1. The maximum benefit payable for expenses incurred as a result of an accident involving s motor vehicle shall be limited to $5,000, for any one accident.

2. When Excess Insurance is provided and another Plan Providing Medical Expense Benefits to an Insured is an HMO, PPO, or similar arrangement for provision of benefits or services, and the accident occurs within the geographic area of the HMO, PPO, or similar arrangement for benefits or services and the Insured does not use the facilities of the HMO, PPO, or similar arrangement for benefits or services, the medical benefits otherwise payable under the Policy shall be reduced by 50%. This limitation shall not apply to emergency treatment required within 24 hours after an accident or when the accident occurs outside the geographic area served by the HMO, PPO, or similar arrangement for benefits or services. NOTE: It is not the intent of the Company to unfairly reduce benefits for any Insured if the Insured is outside the Network Area of their HMO, PPO, or similar arrangement for benefits or services, and no benefits or services are available. The reduction of benefits is only for those Insureds who can use their HMO, PPO, or similar arrangement for benefits or services and have not done so.

NOTICE TO PARENTS

This coverage has been designed to provide maximum benefits at a minimum cost. Benefits will be considered for those eligible expenses which are left unpaid by other insurance or health plans. This claim form must be submitted to the Company within **90 days** from the accident date. **It is the parent's/guardian's responsibility to file the completed claim form within that time period.**

PLEASE NOTE: The Football Accident Insurance contains some benefit limits. Therefore, it may not provide 100% coverage.

How to File a Claim:

1. Obtain an Accident Claim Form from your child's school.
2. Follow the Claim Procedure instructions that are stated on the back of the form, under the heading 'Notice To Parents'.

All correspondence should be directed to:

LEFEBVRE INSURANCE, LLC
850 FRANKLIN STREET
WRENTHAM, MA 02093
(800) 451-9668
(508) 384-0303 - Fax

To Purchase Coverage:

1. Complete all requested information on the Football Enrollment Form.
2. Place completed Enrollment Form, and premium check made payable to 'ACE American Insurance Company', in an envelope.
3. Mail envelope to Lefebvre Insurance LLC, at the address stated above. Coverage will then become effective on the date the Enrollment Form and premium check are received. If the premium check is returned by the bank for any reason, the coverage is null and void.
4. Retain this portion of the Enrollment Form for your records.

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▲ **CUT ON DOTTED LINE** ▲