Vocational & Rehabilitation Training Programs

Accident Insurance Proposal Summary

Accidents Happen.
But that doesn't have to stop your progress.

Our K&K Insurance Participant Accident program provides the assistance or help needed to keep the focus on giving. Our policy provides medical expense benefits as well as death and dismemberment coverage for all eligible persons.

Enrollment Instructions

1. Please carefully read all items of this document before completing and submitting the enrollment form proposal and payment. If you have any questions regarding any information on this document, please contact us accordingly.
2. Complete all items of the enrollment proposal form on page 5.
3. Options for submitting the enrollment form proposal and premium payment are listed on this page to the right.
4. **Please note the premium payment is due with the submission of the enrollment form proposal in order to have the policy issued.**

Enrollment Options

1. **Mail** the enrollment form and payment in its entirety to:
   K&K Participant Accident
   K&K Insurance Group, Inc.
   PO Box 2338, Fort Wayne, IN 46801
2. **Email** the enrollment form and payment in its entirety to groupaccident@kandkinsurance.com
3. **Fax** the enrollment form and payment in its entirety to (260) 459-5903.

Payment Options

1. **Pay by mail**: mail completed enrollment form with payment to address listed above. Checks can be made payable to K&K Insurance Group, Inc.
2. **Pay by credit or debit card**: please email completed enrollment form and call (844) 203-2691
3. **Pay by electronic check (ACH)**: Complete form included with this enrollment proposal (page 8) and email to: groupaccident@kandkinsurance.com

How to Contact Us

1-844-203-2691
(8:00 a.m. – 5 p.m., EST, M-F)

1-260-459-5903

groupaccident@kandkinsurance.com

www.kandkinsurance.com

Administered by:
K&K Insurance Group
PO Box 2338
Fort Wayne, IN 46801-2338

ABOUT THE COVERAGE

1. **Eligible Persons:** All registered participants of the policyholder.
2. **Coverage Effective Date:** The completed application and premium payment must be received prior to the desired policy effective date. Otherwise, coverage will begin the day after the post stamp on the envelope, or the day after the email or fax is received by K&K Insurance Group.
3. **Coverage Expiration Date:** The policy expires 1 year from the coverage effective date at 12:00 am. All coverage ceases if the policyholder cancels the policy or when a person ceases to be an eligible person.
4. **Covered Activities and Condition of Coverage:** While participating in supervised and sponsored Covered Activities of the Policyholder.
   The Covered Loss must take place during:
   A. on the premises of the Policyholder during normal hours of operation or during scheduled functions;
   B. on the premises of the Policyholder during other periods if attending or participating in a Covered Activity; or
   C. away from the premises of the Policyholder while attending or participating in a Covered Activity at its scheduled site.
5. **Coverage benefit period is 2 years from the date of loss.**
6. **Rate Guarantee:** Rates are guaranteed for one year.
7. **Coverage not available** in the following states: MD, NH, NY and WA.

PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic, and procedural safeguards to ensure the security of your nonpublic personal information.

DEFINITIONS

Covered Injury means Accidental bodily injury:
(1) which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force;
(2) which results directly and independently from all other causes from a Covered Accident; and
(3) which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident or Accidental: means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Covered Expenses: means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Medically Necessary: means medical services that:
(1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
(2) meets generally accepted standards of medical practice; and
(3) are ordered by a Physician and performed under His care, supervision or order.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss must occur within 365 days of the Covered Accident

Covered Loss	Benefit Amount
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in Both Ears)	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in Both Ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all Toes of the Same Foot	25% of the Principal Sum
Exposure and Disappearance	Included

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. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
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. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
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. 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;
9. injuries compensable under Workers' Compensation law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
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. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless:
    (a) the Insured Person holds a valid learners permit and
    (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. a cardiovascular, event or stroke resulting, directly and independently of all others causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity;
15. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
16. 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.

ACCIDENT MEDICAL EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that:
   (a) are deemed by the Company to be experimental or investigational; and
   (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. rest cures or custodial care;
7. repair or replacement of existing dentures, partial dentures, braces or bridgework;
8. expenses payable by any automobile insurance policy without regard to fault;
9. 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;
10. treatment of HIV/AIDS, meaning Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC) regardless of the means by which it was acquired;
11. repair or replacement of existing artificial limbs, eyes and larynx;.
12. treatment of Hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed;
13. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician; or
14. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion.

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits.

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

Disclaimer

This product information is for descriptive purposes only and does not provide a complete summary of coverage. Consult the applicable insurance policy for specific terms, conditions, limits, limitations and exclusions to coverage. Not all coverages or options stated above may apply to each policyholder. The coverage for each policyholder will be governed by the terms and conditions of the applicable policy.

Disclosures- Please Read Carefully

U.S. 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. 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. THIS IS A BLANKET ACCIDENT ONLY POLICY.

The Plans are underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909 et al.

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

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

Vocational & Rehabilitation Training Programs

Accident Insurance Enrollment Form Proposal

1. Insured Name: _____
   Group's Name

   Address: _____City _____State _____Zip _____

2. Proposed Policy Term – Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____
   Coverage begins at 12:01am and expires at 12:00am 1 day prior of a year from the effective date. Rates are for 1 year of coverage.

   Please note the earliest we can bind coverage is the day after this submission is sent to K&K Insurance Group

3. **What Are The Program's Activities?:** _____
   _____
   _____

4. Premium Rates by Class of Eligible Persons - check class and Medical Expense Plan Desired

Benefits	Benefit Amounts			
	CLASS 1	CLASS 2	CLASS 3	CLASS 4
Accident Medical Expense	$5,000	$10,000	$25,000	$50,000
Death	$1,000	$2,500	$5,000	$7,500
Dismemberment	$5,000	$5,000	$10,000	$15,000
Deductible	$0	$0	$0	$0

Premium Rates by Class(es) of Eligible Persons		Annual Premium Rates per Eligible Person	
Class	Eligible Persons	☐ Medical Expense PRIMARY Plan	☐ Medical Expense EXCESS Plan
Eligible Persons to be covered: ☐ participants only, or ☐ participants and staff			
1 ☐	Class 1 Benefits	$8.10	$4.95
2 ☐	Class 2 Benefits	$10.25	$6.30
3 ☐	Class 3 Benefits	$13.50	$9.45
4 ☐	Class 4 Benefits	N/A	$13.05

PREMIUM REPORT					
	Number of Eligible Persons			Annual Premium Rate per Eligible Person	Premium Due
Program Description	Participants	Staff	Total		
☐ Vocational Training Program	+	=	X	=	
☐ Rehabilitation Training Program	+	=	X	=	
Total Premium Due (Subject to Minimum Premium):					
The annual minimum premium per policy is $400 for PRIMARY coverage and $300 for the EXCESS coverage					

Continue to next page

5. Coverage not available in the following states: **NH and WA**.
6. It is understood and agreed that: (a) the premium will be paid entirely by the insured with no contribution made by the eligible persons toward the cost of the insurance; and (b) all eligible persons will be reported and insured.
7. I verify that the information provided on this enrollment form is correct and I would like to bind coverage. This binder shall remain in force for 30 days from the effective date or when, if earlier, it is replaced by a policy of AXIS Insurance Company. I further acknowledge that, I have reviewed all information provided, including the warranty and disclosure statements on page 4 with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided.

To the best of my knowledge and belief all statements made in this Application for Insurance are true. Agreeing electronically to this document does not bind the Applicant to purchase the insurance, but it is agreed that this Application shall be the basis of the contract, should a policy be issued. In order to complete your application and receive a quotation, please indicate your agreement below with a YES.

Please check the box and type your name as an electronic signature OR provide your signature on the line provided to agree to the terms and conditions of the policy.

The customer has agreed electronically Yes ☐

Applicant Signature	Agent/Broker's Signature
Printed Name of Applicant's Authorized Representative	Printed Name of Agent/Broker's Authorized Representative
Applicant Phone Number	Name of Agency/Broker
Applicant's Email	Agency/Broker Phone Number
Date	Address of Agency/Brokerage
Account ID #	Policy Document Delivery

Payment Options:

1. **Email Electronic Check (ACH):** Complete the form on page 8 and email the form with the application to us at groupaccident@kandkinsurance.com.
2. **Pay with Credit/Debit Card:** Email the completed application to groupaccident@kandkinsurance.com and then call 844-203-2691 to make payment.
3. **Pay by Mail:** Mail the completed enrollment form with check to: K&K Participant Accident PO Box 2338, Fort Wayne, IN 46801

SUBMIT

Click the SUBMIT tab to start the process
of emailing this submission to K&K Insurance

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 California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **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 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 Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- **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 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 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.

FRAUD 1122

ACH Authorization Form

As a service to our customers, this form may be used in lieu of submitting a check for payment.
Please complete a separate form for each transaction.

Check One: ☐ New Business ☐ Renewal ☐ Policy Endorsement

Insured Name: _____

I (we) authorize K&K Insurance (Aon) to initiate a single electronic debit from the account and depository shown below:

Name on Bank Account:_____ Bank Name:_____

Draft Amount: $_____ ☐ Checking or ☐ Savings

Bank Account Routing/Transit Number*:_____ Bank Account Number*: _____

*See below for an explanation of where to locate these two sets of numbers on your bank check.

_____ _____

Authorized Signature(s) Date

_____

Authorized Signature(s)

To protect the integrity of this program, please maintain a bank balance sufficient to honor charges presented for payment. If you change banking arrangements, sufficient funds should be left in the account to honor charges presented for payment.

EXPLANATION OF CHECK NUMBERS

1. Bank Routing/Transit Number — This is a nine digit number separated by a bar and a colon |: 123456789 |:
2. Account Number — This number may appear as the second, first or third series of numbers. Please read carefully.
3. Check Number — Matches number in the upper right corner of check. NOT REQUIRED FOR ACH.



SUBMIT

Click the SUBMIT tab to start the process
of emailing this submission to K&K Insurance