Special Risk ACCIDENT POLICY

Fidelity Security Life Insurance Company KA-102 KA-103

APPLICATION FOR INSURANCE

Mail with your check or money order made payable to Forrest T. Jones & Co., Inc. to:

Group Insurance Administrative Office ATTN: Property/Casualty Department 3130 Broadway • PO Box 418131 Kansas City, MO 64141-9131 Any questions? Call: (800) 821-7303

Is the institution for which coverage is being applied accredited by the National Association for the Education of Young Children (NAEYC)? IF YES, please give the NAEYC Academy Program Code No. Please complete the following if any student was required to have any emergency medical treatment as a result of an accident while under the supervision of your center within the past three years. YEAR NUMBER OF ACCIDENTS TOTAL AMOUNT OF MEDICAL EXPENSES	Name of Cente	er				
Desired Effective Date From: To: Are teachers and supervisors to be covered? Is the institution for which coverage is being applied accredited by the National Association for the Education of Young Children (NAEYC)? IF YES, please give the NAEYC Academy Program Code No. Please complete the following if any student was required to have any emergency medical treatment as a result of an accident while under the supervision of your center within the past three years. YEAR NUMBER OF ACCIDENTS TOTAL AMOUNT OF MEDICAL EXPENSES Has any child died of accidental causes while under the supervision of your center? If yes, provide details. Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defraudit 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. I hereby certify that the number of insured persons shown on the reverse is accurate according to the information a records of the participating group and that all students being insured and premium paid accordingly. Signature Date	Contact Name			Telephone ()	
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TO APPLY FOR THE SPECIAL RISK ACC	CIDENT PO	LICY:			
1 Choose your coverage option and calculate	e your premit	um using the	e worksheet bel	low.	
Provide a list of the students' names and as (and all teachers and supervisors if benefit	ges selected).				
Provide a copy of your licensing certificate	•		ATTN: Prop	perty/Casua	inistrative Office alty Department
Mail all items and your check in the enclose CHOOSE YOUR COVERAGE OPTION:	sed envelope	to:	→ 3130 Bros	adway • PO	O Box 418131 64141-9131
FULL-DAY: 9-month 12-month PRIMARY PLAN pays benefit	efit first (befor	ore other insu	• /	ıms (June, Ju	ly, & August)
HALF-DAY: (includes before-and-after school If center has both full-day and hal	ılf-day prograı	☐ 12-mon	program		erm only
EXCESS PLAN available on	ıly				
CHOOSE YOUR DEDUCTIBLE: \$0 \$100					
CALCULATE YOUR PREMIUM:					
Total Number of Students, Teachers and Supervisors	Premium Amount from Table Below		Total Amount Due (if NAEYC-accredited, reduced total by 10%)		
X _			. =		
PREMIUN	MS PER CO	VERAGE	PERIOD		
			II-Day		Half-Day**
Deductible Coverage Type	\$0 Primary	\$0 Excess	\$10 Primary	00 Excess	\$0 Excess Only
12-Month Plan All Students, Teachers and Supervisors	\$10.40	\$4.25	\$8.70	\$3.50	\$3.00
9-Month Plan (for 9-month school term only) All Students, Teachers and Supervisors	\$7.60	\$3.10	\$6.40	\$2.50	\$2.20
3-Month Plan (summer only) [♦] All Students, Teachers and Supervisors	\$4.05	\$1.65	\$3.40	\$1.35	Not available
Minimum premium for the Primary Plan is \$250: Special note: <i>Premiums are per covered person.</i>					
** If center conducts both full- and half-day prog Summer only plan coverage for June, July and		te as full-day.			

10% premium discounts for NAEYC-accredited centers!