UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET ACCIDENT APPLICATION

1.POLICYHOLDER INFORMATION

Applicant/Policyholder (Full Legal Name) Turkeyfoot Valley School District

Office Address 172 Turkeyfoot Rd

City Confluence State PA Zip Code 15424

Phone Number _____ FAX Number _____

Type of business or organization: K-12 School District

Covered Activities: Students purchasing the voluntary student accident coverage including sports other than football

Duration of Covered Activities: August 1, 2023 to August 1, 2024

2. Requested Effective Date: August 1, 2023

3. **Class of Eligible Persons**: Policyholder Registered and Enrolled Students

4. **Description of Benefits**

Voluntary Student Accident Plan PA-CA Primary Excess $100
Accident Medical Benefits: $250,000
Benefit Period: 1 year
Accidental Death and Dismemberment: $2,500 Death / $20,000 Double Dismemberment
Premium: School Time $70.00 per student / 24 Hour $150.00 per student

Persons who qualify within the Plans and classes described below are eligible to be insured under the Policy.

The Applicant/Policyholder agrees to the following terms.

1. The Applicant will promptly furnish any records or other information necessary to insure the proper administration of the insurance plans to the Underwriting Company. The Applicant further agrees to allow the Underwriting Company or its Administrator to examine all records that pertain to the insurance plans.
2. The consideration for the requested insurance is the Underwriting Company's acceptance of this application and the Applicant's payment of the required premium when due. Payment of the required premium, if any, after delivery of the policy acts as acceptance of the terms and conditions of the policy.

The Applicant represents that the information provided to the Underwriting Company to determine the terms of the insurance applied for is true and correct and forms the basis of the requested insurance.

IMPORTANT NOTE: 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.

ACCEPTANCE:

_____ Date:_____

(Signature and Title of Applicant's Authorized Representative)

_____

(City and State)

Accepted by: _____ Date: _____

(Signature and Title of Underwriting InsuranceCompany Representative)

***FOR COMPANY USE ONLY*:**

SALES OFFICE: AG Administrators LLC BROKER/AGENT: Reschini Agency Inc