SENTRY LIFE INSURANCE COMPANY

2008–2009 North Carolina Primary Student Accident Insurance Coverage

SCHOOL-TIME ACCIDENT COVERAGE – Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity. No coverage is provided while participating in Senior High Interscholastic Sports.

Annual Premium: **Gold – $33.00** **Silver – $22.00** **Bronze – $11.00**

OPTIONAL 24-HOUR ACCIDENT COVERAGE – Insurance coverage is provided for covered injuries around the clock, 24-Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. No coverage is provided for participation in Senior High Interscholastic Sports.

Annual Premium: **Gold – $150.00** **Silver – $100.00** **Bronze – $50.00**

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24-Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.

Annual Premium: **$7.00**

COVERAGE PERIOD – Coverage under the School-Time Accident Coverage and the Optional 24-Hour Accident Coverage begins on the date of premium receipt but not before the start of the school year activities. School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending activities exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

SCHEDULE OF BENEFITS

Coverage for Injuries due to Accident only

Maximum Benefit	**GOLD**	**SILVER**	**BRONZE**
School-Time Option	$100,000	$75,000	$50,000
24-Hour Option	$100,000	$75,000	$50,000
Injuries Involving Motor Vehicles	$ 10,000	$10,000	$10,000
Death Benefit	$ 10,000	$10,000	$10,000
Single Dismemberment Benefit	$ 5,000	$ 5,000	$ 5,000
Double Dismemberment Benefit	$ 10,000	$10,000	$10,000
Loss Period	Treatment must begin within 60 days from the date of Injury	Treatment must begin within 60 days from the date of Injury	Treatment must begin within 60 days from the date of Injury
Benefit Period	One Year	One Year	One Year
Hospital/Facility Services – Inpatient			
Hospital Room & Board (Semi Private Room)	100% U&C	100% U&C	100% U&C
Hospital Intensive Care	100% U&C	100% U&C	100% U&C
Inpatient Hospital Miscellaneous	$1,000 1st day / $500 ea thereafter / $10,000 Max.	$750 1st day / $375 ea thereafter / $7,500 Max.	$500 1st day / $250 ea thereafter / $5,000 Max.
Hospital/Facility Services – Outpatient			
Free-standing Ambulatory Surgical Facility	$2,000 Maximum	$1,000 Maximum	$500 Maximum
Outpatient Hospital Miscellaneous-(except physician services and x-rays paid as below)	$750 Maximum	$500 Maximum	$250 Maximum
Emergency Room Physician	$75	$50	$25
Hospital Emergency Room	$500 Maximum	$350 Maximum	$250 Maximum
Physician's Services			
Surgical	80% U&C / $3,000 Max	80% U&C / $2,000 Max	80% U&C / $1,000 Max
Assistant Surgeon	25% of surg. benefits	25% of surg. benefits	25% of surg. benefits
Anesthesiologist	25% of surg. benefits	25% of surg. benefits	25% of surg. benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	$75/visit / 5 visits Max	$40/visit / 5 visits Max.	$25/visit / 5 visits Max.
Physician's Non-surgical Treatment (Except as above)	$60/Visit	$40/visit / $500 Max.	$25/visit
Other Services			
Registered Nurses' Services	100% U&C	100% U&C	100% U&C
Prescriptions - outpatient	100% U&C	100% U&C	100% U&C
Laboratory Tests Outpatient	Covered Outpat. HM	Covered Outpat. HM	Covered Outpat. HM
X-rays, includes interpretation – outpatient	$300 Maximum	$250 Maximum	$150 Maximum
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation - outpatient	$1,000 Maximum	$750 Maximum	$500 Maximum
Ground Ambulance	$500 Maximum	$400 Maximum	$300 Maximum
Air Ambulance	$1,500 Maximum	$1,000 Maximum	$500 Maximum
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	$500 Maximum	$400 Maximum	$300 Maximum
Dental Treatment to sound, natural teeth due to covered injury.	$600 / tooth	$400 / tooth	$200 / tooth
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	$700 Maximum	$500 Maximum	$300 Maximum

140-50 (NC-YG1) 5/08

ENROLLMENT APPLICATION

Student's Last Name (please print or type)

Student's First Name Student's Middle Initial

Social Security # _____ Birthdate _____ Grade _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

School System _____

Name of School _____

Signature of Parent or Guardian _____

Date _____

140-50 (NC-YG1)

Student Accident Insurance - check [x] your selections:

2008–2009 ANNUAL PREMIUM

Coverage Plans	**Gold**	**Silver**	**Bronze**
School-Time Accident Coverage*	$ 33.00 ❑	$ 22.00 ❑	$ 11.00 ❑
Optional 24-Hour Accident Coverage*	$ 150.00 ❑	$100.00 ❑	$ 50.00 ❑
Optional 24-Hour Dental Coverage	$ 7.00 ❑	$ 7.00 ❑	$ 7.00 ❑

Please make check payable to **Sentry Life Insurance Company**.

Total Enclosed $ _____

***All Premiums listed are for [Grades K - 12.]**

❑ I have adequate insurance and do not want this insurance.

Signature of Parent or Guardian Date 5/08

FULL PRIMARY COVERAGE

Benefits are payable for covered medical expenses from the first dollar of expense incurred. Benefits are paid in addition to and without regard to payments from other insurance.

MEDICAL BENEFITS

When a covered Injury to a student results in treatment by a legally qualified physician or surgeon (other than a member of the family) or is hospital confined, and treatment begins within 60 days from the date of Injury, the Company will pay benefit as shown in the Schedule of Benefits, subject to the primary coverage provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the accident are covered. Benefits for any one accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT

When a covered Injury results in any of the Losses to the student, We will pay the benefit stated in the schedule for that Loss. The Loss must be sustained within 365 days from date of Injury. The following benefits (the largest applicable amount) are paid in addition to the medical benefit:

Loss of life:	$10,000
Loss of one hand, one foot, or sight in one eye:	$ 5,000
Loss of both hands, both feet, or sight in both eyes:	$10,000

Loss of hand or foot means the actual and complete severance through or above the wrist or ankle. Loss of sight means irrecoverable loss of sight. These Losses will be considered total and irrecoverable if such loss cannot be restored or corrected by medical or surgical treatment. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount We will pay is the maximum benefit.

DEFINITIONS

Injury means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event producing objective symptoms of an Injury within 72 hours of the Injury. The Accident must occur while the Insured is covered under the Policy. **Reasonable Expense** means the usual, reasonable and customary fee or charge for the services rendered and the supplies furnished in the area where and at the time such services are rendered or supplies furnished, as determined by Us. Such services and supplies must be recommended and approved by a Physician.

EXCLUSIONS

No Benefits are payable for Hospital and Professional Services for the following:

1. Injuries which are not caused by an Accident; 2. Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis; 3. Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile; 4. Re-Injury or complications of a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a 6 month period preceding the Policy Effective Date; 5. Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid; 6. Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; 7. Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School; 8. Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; the taking part in any illegal occupation; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or being under the influence of any drugs or narcotic unless administered by or on the advice of a Physician; 9.Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, the employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act; 10. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. If there is any conflict between this brochure and the policy, the policy will prevail.

HOW TO FILE A CLAIM

1) Obtain claim form from your school office or the marketing agent and answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident. 2) If you have other insurance, submit your claim to your other insurer. When you receive the **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**, send it to us along with the corresponding **ITEMIZED BILLS** with diagnosis along with this fully completed claim form. **KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.** 3) If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted. 4) Mail all correspondence to Sentry Life Insurance Company, Policy Benefits, P.O. Box 8025, Stevens Point, WI 54481. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with student's name, school district and date of Accident. 5) If you change your address, please notify Sentry Life Insurance Company by calling 1-800-426-7234 so that there is no delay in processing any claims. Please contact Sentry Life Insurance Company by calling 1-800-426-7234 if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

UNDERWRITTEN BY:

SENTRY LIFE INSURANCE COMPANY

1800 North Point Drive, Stevens Point, WI 54481

MARKETING AGENT:

The Young Group, Inc.
256 West Millbrook Road, Raleigh, NC 27609
(919) 846-9798

To apply for coverage, please cut along the dotted line. Complete the form and mail it, along with your check or money order, to the address shown below.

Please Return To:
The Young Group, Inc.
256 West Millbrook Road
Raleigh, NC 27609