

BOX ELDER SCHOOL DISTRICT
960 SOUTH MAIN STREET
BRIGHAM CITY, UT 74302

RE: Policy number: 6AJXS28091700

Dear Sir or Madam:

Thank you for the opportunity to help serve your insurance needs and those of your students and employees.

Enclosed is your policy. Please review the coverage, limits and exclusions and contact us if you have any questions or concerns about it.

The benefits and limits you requested (student accident insurance) are similar to that issued by another insurance company. Because the customized coverage is significantly different from that which is normally provided in the Nationwide Life Insurance Company Specified Hazard Blanket Insurance Policy, form series GR-9050, we are obliged to confirm that you understand the restrictions and exclusions which are included in the Nationwide policy.

The premium and rates are due to limitations and exclusions and other adjustments to the benefits. Those benefit adjustments are shown on the application and alter the policy in order to match up with the coverage in the brochure from which you made your selection of coverage. The application becomes part of the policy. Two copies of the application are enclosed. One is in the body of the policy. The second directly follows the two copies of this letter. Please sign both applications and return the second one to K&K as soon as possible.

Return to K&K

1. A signed copy of this letter to indicate that you acknowledge the benefit adjustments
2. A signed application to issue the policy

We appreciate your business and look forward to working with you.

Sincerely,

K&K Insurance Group, Inc.

Enclosure

Please sign below and return one copy to K&K
Signature
Title and Date

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BRIGHAM CITY, UT 74302

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 <i>Signature</i>
 <i>Title and Date</i>



**SPECIALTY
BENEFITS, INC.**
an affiliate of K&K Insurance Group, Inc.



**STUDENT OR ATHLETE
ACCIDENT CLAIM FORM**
Excess Coverage
K-12 ACCOUNTS

CLAIMS DEPARTMENT

1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 Fax: 312-381-9077 California License #0334819
www.kandkinsurance.com

POLICY NUMBER: JXS0000028091700

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: _____ First: _____ MI: _____

2. Date of Birth: _____ SS# _____ Sex: Male Female

3. Student's grade in school: _____

4. Home Address Street: _____

City: _____ State: _____ Zip: _____

Parent(s)/Guardian(s) Home Phone: _____

5. Date of Accident: _____ Time of Accident: _____ AM PM

Nature of Injury: _____ Describe exactly how accident happened: _____

6. Nature of activity and location during which the injury occurred (check all boxes which apply):

- | | | |
|--|--|--|
| <input type="radio"/> Pre-Kindergarten | <input type="radio"/> Elementary School | <input type="radio"/> Middle School |
| <input type="radio"/> High School | <input type="radio"/> Cafeteria | <input type="radio"/> Classroom Activities |
| <input type="radio"/> Interscholastic Sports | <input type="radio"/> Intramural Sports | Name of Sport, if applicable: _____ |
| <input type="radio"/> Club Sports | <input type="radio"/> Physical Education Class | <input type="radio"/> Other Activity (specify) _____ |
| <input type="radio"/> During Practice | <input type="radio"/> During Play | <input type="radio"/> During Travel To or From the Event |

Nature of Your Participation:

- | | | |
|---|-----------------------------------|---------------------------------------|
| <input type="radio"/> Student | <input type="radio"/> Volunteer | <input type="radio"/> Student/Manager |
| <input type="radio"/> Athletic Participant | <input type="radio"/> Cheerleader | <input type="radio"/> Band Member |
| <input type="radio"/> Other (specify) _____ | | |

7. Transfer Student? Yes No

If yes, please identify the former school name: _____

8. Name, address and phone number of physician who first treated you: _____

9. Have you had a similar injury in the past? Yes No

If yes, describe and give dates: _____

10. Name, address and phone number of physician who treated you for previous injury: _____

11. Are you covered by any other medical expense benefits plan? Yes No

If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits and/or Nationwide Life Insurance Company or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date _____ Parent/Guardian Signature _____

SECTION II

(TO BE COMPLETED BY PARTICIPATING SCHOOL)

**FAILURE TO COMPLETE THIS FORM IN FULL
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.**

1. Student's Name Last: _____ First: _____ MI: _____

2. Date of Accident _____

3. Activity _____

4. Nature of Injury _____

5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT _____

6. Name of participating SCHOOL _____

7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNATURE OF SCHOOL OFFICIAL: _____

PRINTED NAME/TITLE: _____

PHONE: _____ FAX: _____

EMAIL: _____ DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files forms 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.

Date _____ Policyholder (School Official) Signature _____



CLAIMS DEPARTMENT
 1712 Magnavox Way, P. O. Box 2338 | Fort Wayne, IN 46801-2338
 Ph: 800-237-2917 | Fax: 260459-5915 California License #0334819
www.kandkinsurance.com

OTHER INSURANCE QUESTIONNAIRE

POLICY NUMBER: JXS0000028091700

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT Yes No

EMANCIPATED STUDENT: Yes No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: Yes No

NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IS FATHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
SOCIAL SECURITY #: _____	SOCIAL SECURITY #: _____
EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: () _____	PHONE: () _____
CONTACT PERSON: _____	CONTACT PERSON: _____
Do you have group medical insurance coverage through your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have group medical insurance coverage through your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COMPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGE <input type="checkbox"/> OTHER (describe) _____	TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGES <input type="checkbox"/> OTHER (describe) _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____ PARENT/GUARDIAN/MOTHER SIGNATURE: _____

DATE: _____

DATE: _____

FACTS	WHAT DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> • Social Security number, government issued identification, and contact information • Policy, account, and contract information • Credit reports and other consumer reports
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

To limit our sharing	<ul style="list-style-type: none"> • Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices. • If you have previously opted out, your preference remains on file and you do not need to opt out again. • Please have your account or policy number handy when you call. <p>Please note: If you are a <i>new</i> customer, we can begin sharing your information 30 days from the date we sent this notice. When you are <i>no longer</i> our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.</p>
Questions?	1-800-237-2917

Who we are	
Who is providing this notice?	Nationwide Life Insurance Company
What we do	
How does Nationwide protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.

How does Nationwide collect my personal information?	We collect your personal information, for example, when you: <ul style="list-style-type: none"> • Apply for insurance • Make a payment or file a claim • Conduct business with us We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal and state law gives you the right to limit only: <ul style="list-style-type: none"> • Sharing for affiliates' everyday business purposes—information about your creditworthiness; • Affiliates from using your information to market to you; and • Sharing for nonaffiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. See below for more information.

Definitions	
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Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. These companies include Nationwide Life Insurance Company, Nationwide Bank, and Nationwide Property and Casualty Insurance Company. Visit nationwide.com for a list of affiliated companies.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Other important information	
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California Residents: We currently do not share information we collect about you with affiliated or nonaffiliated companies for their marketing purposes. Therefore, you do not need to opt out.

Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to privacy@nationwide.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3132; email: BCPINFO@ag.state.nv.us.

Vermont Residents: For Vermont customers only. We will not share your personal information for marketing purposes with the Nationwide family of companies or third parties without your authorization, except as permitted by law.

AZ, CA, CT, GA, IL, ME, MA, MT,NV, NJ, NM, NC, ND, OH, OR, and VA Residents: When we refer to “Information” we mean information we collect during an insurance transaction (not including medical record information). We will not use your medical information for marketing purposes without your consent. We share personal information with nonaffiliates without your prior authorization as permitted or required by law. They may use it to investigate fraud, respond to court orders, and conduct actuarial studies. We share it with insurance regulatory authorities and law enforcement. We share it with consumer reporting agencies. They may retain it or disclose it to other companies with which you do business. These other companies use and disclose it to others as permitted by law. We obtain reports prepared by an insurance-support organization. The insurance-support organization keeps copies and discloses them to others. You have a right to access and correct your Information as described below.

Accessing your information

You can ask us for a copy of your personal information. Please send your request to the address below and have your signature notarized. This is for your protection so we may prove your identity. Please include your name, address, and policy number. You can change your personal information at Nationwide.com or by calling your agent. We can't change information that other companies, like credit agencies, provide to us. You'll need to ask them to change it.

K&K Insurance Group, Inc.
Attn: Privacy Manager
1712 Magnavox Way
P.O. Box 2338
Fort Wayne, IN 46801-2338

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 in hospital, medical and surgical insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in disability income insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Association
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

POLICY APPLICATION (please print or type)

which, upon acceptance and approval by **NATIONWIDE LIFE INSURANCE COMPANY -- Columbus, Ohio 43216**, will become a part of **SPECIFIED HAZARD INSURANCE POLICY NUMBER : 6AJXS28091700**

1. Name of Plan Sponsor: BOX ELDER SCHOOL DISTRICT
(Group's Name)

Permanent Mailing Address: 960 SOUTH MAIN STREET, BRIGHAM CITY, UT, 74302
(Street) (City) (State) (Zip) (County)

2. Policy Term: The policy term starts at 12:01 a.m. on 8/1/2017, which is the effective date and ends at 12:01 a.m. on 8/31/2018, which is the termination date.

3. Covered Activities

For each class of persons, covered activities are as described below.

<u>Class</u>	<u>Description of Activities</u>
1 & 2	All activities, excluding high school football
3 & 4	All activities between the last day of the school year commencing during the policy period and the first day of the following school year.
5 & 6	Participating in or attending any Policyholder sponsored activity, excluding high school football; or while traveling to or from the Insured Person's residence and the Policyholder's premises on days when the Insured Person has regularly scheduled classes or work and within one hour of the scheduled start of or dismissal from the scheduled class or work or at any other time if traveling by transportation furnished or approved by the Policyholder.
7, 8, 9 & 10	Practice or play of football in accordance with the rules of the state high school athletics authority. Group or team travel supervised by the Policyholder to or from a practice or play is covered if in a vehicle furnished or approved by the Policyholder.

4. Maximum Benefit Amounts -- the word "None" means the benefit is not included.

Benefit Provisions	Maximum Benefit Amounts
	Classes 1, 3, 5, 7 & 9
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$100,000.00 overall maximum for any one accident.	
Death	\$10,000
Specific Loss (Face Amount)	\$10,000
MEDICAL EXPENSE - Accident	
Deductible	\$0
Overall Maximum	\$25,000

The ACCIDENT MEDICAL EXPENSE BENEFIT is modified as follows:
 1) The deductible is reduced by amounts paid by Other Insurance.
 2) Medically necessary professional ambulance service is a Covered Expense.
 3) Covered Expenses does not include Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care and Durable Medical Equipment.
 4) The following Covered Expenses limitations apply. Limitations are per Insured per Injury, unless otherwise specified.

Office Use Only: LOW

Covered Expenses	Covered Expense Limitations
Inpatient Hospital Services	
Room & Board – Semi-Private or Private	Maximum \$150 per day
Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum \$600 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	75% of R&C

Emergency Room Services (including use of the emergency room and supplies)	Maximum \$150 if rendered within 72 hours of Injury
Physician Services	
Physician Non-Surgical Services	Maximum \$40 for the first visit, and \$25 for each subsequent visit, limited to one visit per day
Physician Surgical Services, Inpatient or Outpatient	Maximum \$1,000 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum \$200
Assistant Surgeon	20% of Physician Surgical Maximum
Anesthetist Services [(not including supervision of an anesthetist)	20% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum \$1,000
X-Ray Services	Maximum \$200 for Outpatient
Diagnostic Imaging Services	Maximum \$300 for Outpatient
Laboratory Services	Maximum \$50 for Outpatient
Combined Ground and Air Ambulance Services	Maximum \$300
Orthopedic Braces and Appliances	Maximum \$75
Dental Services	Maximum \$10,000
Outpatient Physical Therapy	Maximum \$30 for the first visit, and \$20 for each subsequent visit for a maximum of 5 visits, limited to one visit per day
Prescription Drugs	Maximum \$75
R&C = Reasonable and Customary Charges	

4. Maximum Benefit Amounts -- the word "None" means the benefit is not included.

Benefit Provisions	Maximum Benefit Amounts
	Classes 2, 4, 6, 8 & 10
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$100,000.00 overall maximum for any one accident.	
Death	\$10,000
Specific Loss (Face Amount)	\$10,000
MEDICAL EXPENSE - Accident	
Deductible	\$0
Overall Maximum	\$25,000

The ACCIDENT MEDICAL EXPENSE BENEFIT is modified as follows:

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- 2) Medically necessary professional ambulance service is a Covered Expense.
- 3) Covered Expenses does not include Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care and Durable Medical Equipment.
- 4) The following Covered Expenses limitations apply. Limitations are per Insured per Injury, unless otherwise specified.

Office Use Only: HIGH

Covered Expenses	Covered Expense Limitations
Inpatient Hospital Services	
Room & Board – Semi-Private or Private	80% of R&C
Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum \$1,200 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	100% of R&C

Emergency Room Services (including use of the emergency room and supplies)	Maximum \$300 if rendered within 72 hours of Injury
Physician Services	
Physician Non-Surgical Services	Maximum \$60 for the first visit and \$40 for each subsequent visit , limited to one visit per day
Physician Surgical Services, Inpatient or Outpatient	Maximum \$1,200 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum \$400
Assistant Surgeon	25% of Physician Surgical Maximum
Anesthetist Services [(not including supervision of an anesthetist)	25% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum \$1,200
X-Ray Services	Maximum \$600
Diagnostic Imaging Services	Maximum \$600
Laboratory Services	Maximum \$300
Combined Ground and Air Ambulance Services	Maximum \$800
Orthopedic Braces and Appliances	Maximum \$140
Dental Services	Maximum \$10,000
Outpatient Physical Therapy	Maximum \$60 for the first visit and \$40 for each subsequent visit , for a maximum of 5 visits
Prescription Drugs	Maximum \$200
R&C = Reasonable and Customary Charges	Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care

5. Premium Rates by Class of Eligible Persons

Class	Eligible Persons	Premium per Participant per Year
		Medical Expense Excess Plan
1	Students and employees on whose behalf the required premium contribution is made for Low Option 24-Hour coverage.	As stated in the brochure
2	Students and employees on whose behalf the required premium contribution is made for High Option 24-Hour coverage.	As stated in the brochure
3	Students on whose behalf the required premium contribution is made for Low Option Summer Only coverage.	As stated in the brochure
4	Students on whose behalf the required premium contribution is made for High Option Summer Only coverage.	As stated in the brochure
5	Students and employees on whose behalf the required premium contribution is made for Low Option At-School coverage.	As stated in the brochure
6	Students and employees on whose behalf the required premium contribution is made for High Option At-School coverage.	As stated in the brochure
7	Student members of the High School Football team on whose behalf the required premium contribution is made for full football season Low Option coverage.	As stated in the brochure
8	Student members of the High School Football team on whose	As stated in the brochure

	behalf the required premium contribution is made for full football season High Option coverage.	
9	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football Low Option coverage.	As stated in the brochure
10	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football High Option coverage.	As stated in the brochure

Particip
Care p

The minimum premium per policy term is \$175.00.

6. The policy is to cover all eligible persons..

7. It is understood and agreed that the premium will be paid entirely as agreed between the Plan Sponsor and the Company.

(Previous Policy Number)

BY _____
(Signature of Applicant)

(Date)

(Printed Name and Title of Applicant)

K & K Insurance Group, Inc. 13-0090572

960 SOUTH MAIN STREET
BRIGHAM CITY, UT, 74302

(Agent's Signature and Number)

(Address of Applicant)

GR-9050

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.

POLICY NUMBER: 6AJXS28091700

NATIONWIDE LIFE INSURANCE COMPANY



Home Office: P.O. Box 2399
Columbus, Ohio 43216

SPECIFIED HAZARD INSURANCE POLICY

Thank you for taking this policy with us.

Policy No. 502 - 6AJXS28091700

INSURING AGREEMENT - We promise to pay, subject to the terms of this policy, the benefits stated herein. We make this promise and issue this policy to you in exchange for the premium shown in the application. This policy is a legal contract between you and us.

POLICY TERM - The policy term starts and ends at 12:01 a.m. standard time at your address on the effective and termination dates shown in the application. The contract cannot be renewed.

TABLE OF CONTENTS

Table listing contents: Insuring Agreement, Policy Term, Key Words Defined, Premium, Term of a Person's Coverage, The Maximum Benefit Amounts, Exclusions and Limitations, Accidental Death and Specific Loss Benefit Page, Accident Medical Expense Benefit Page, Application, Claims Information, General Information, State Exceptions (If Any), Attached Riders.

KEY WORDS DEFINED - When we use these words, we mean:

You, your, or plan sponsor - the plan sponsor named in the application.

We, our, us, or Nationwide - the Nationwide Life Insurance Company.

Application - the attached policy application which is part of the contract.

Eligible person - a person described under (one of) the class(es) of eligible persons listed in the application.

Insured - an eligible person insured under the contract.

Covered activities - the covered activities described in the application.

Injury - a bodily injury which meets all of the following conditions: (1) it is caused solely by an accident which happens while the contract is in force on the insured and while he or she is taking part in a covered activity; (2) it results in loss or expense covered by the contract; and (3) neither the injury, the loss, nor the expense may result from sickness, disease, or bodily infirmity, or from any cause other than the accident.

Reasonable and customary charges - (1) reasonable in terms of services, care, or treatment provided; and (2) customary in that charges made by a provider are in line with charges made by providers of similar training and experience for a similar service within the same area.

Doctor - a person duly licensed and legally qualified to diagnose and treat injury. Such person must be providing services within the scope of his or her license. The term "doctor" does not include the insured.

THIS IS LIMITED ACCIDENT INSURANCE. IT IS AN ACCIDENT ONLY POLICY AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. PLEASE READ YOUR POLICY CAREFULLY.

PREMIUM - The premium rates and the method of payment are shown in the application. The premium is due on the date coverage begins. The premium must be paid to our Home Office or to one of our agents.

TERM OF A PERSON'S COVERAGE - A person's coverage begins on the later of: (1) the effective date of the contract; or (2) when he or she becomes an eligible person.

An insured's coverage ends on the first of these to occur: (1) when he or she is no longer an eligible person; or (2) the date to which premium has been paid; or (3) the termination date of the contract. Termination of coverage will not affect a claim which occurs before the coverage ends.

THE MAXIMUM BENEFIT AMOUNTS which apply to an insured are shown in the application to the right of the benefit provision(s) for which he or she is insured.

EXCLUSIONS AND LIMITATIONS - We will not pay benefits for covered expenses incurred for:

- (1) the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids;
- (2) treatment by a person employed or retained by you or your subsidiaries or affiliates and for which no charge is normally made; or
- (3) care or treatment by a person who ordinarily lives in the insured's home or is a parent, grandparent, spouse, brother, sister, or child of either the insured or the insured's spouse.

Nor will we pay benefits for loss or covered expenses resulting from:

- (4) intentional self-destruction or an attempt at it, or intentional self-inflicted injury while sane or insane (if a Missouri contract, while sane);
- (5) war or an act of war, declared or undeclared; or
- (6) air travel unless the insured is a passenger on a regularly scheduled flight of a properly licensed commercial airline.

POLICY NUMBER: 6AJXS28091700
 ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT

Death- If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay, subject to the overall maximum for any one accident, the death benefit which applies less any specific loss benefit paid because of the same accident. The one year limit does not apply in a Pennsylvania contract.

Specific loss- If, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay, subject to the overall maximum for any one accident, a benefit based on the face amount which applies to the insured as specified in the table below.

Loss of:	For the	Percent of the	Face Amount
	Each Arm	75%	
	Each Leg	75%	
	Each Hand	50%	
	Each Foot	50%	
	Sight of Each Eye	50%	
	Speech	50%	
	Hearing of Each Ear	25%	
	Thumb and Index Finger of the Same Hand	25%	

Specific loss means the total, permanent, and irrecoverable loss of:

- (1) a natural arm or leg severed at or above the elbow or knee joint;
- (2) a natural hand or foot severed at or above the wrist or ankle joint;
- (3) the entire sight of an eye, entire speech, or entire hearing of an ear; or
- (4) a natural thumb and index finger severed at or above the joints which attach them to the hand.

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount shown in the application. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

The overall maximum for any one accident is shown in the application. This is the maximum amount payable by us for all death and specific loss claims incurred for all insureds under the contract which are caused by any one accident. If this is not enough to pay the total of all such claims, then the amount we will pay for the death or specific loss of any one insured will be his or her proportional share of this amount.

POLICY NUMBER: 6AJXS28091700

ACCIDENT MEDICAL EXPENSE BENEFIT-if, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible (if any) shown in the application and not to exceed the maximum benefit amounts shown therein, all covered expenses incurred within 3 years from such dates.

Covered expenses mean the reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following reasonable and customary charges for treatment, services, and supplies provided or prescribed by a doctor:

- (1) hospital or surgical center care;
- (2) medical treatment;
- (3) nursing care provided by a licensed nurse;
- (4) X-rays and lab exams;
- (5) prescription drugs and therapeutic services and supplies;
- (6) dental treatment as a result of injury to sound, natural teeth; and
- (7) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or skilled nursing home confinement: (a) physical, occupational, respiratory, and speech therapy, (b) the services of a home health aide, and (c) medical supplies.

If the application indicates that the excess plan applies, we will not pay benefits for, nor can the deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under:

- (1) another insurance contract or prepayment plan;**
- (2) a trusteed, union, employer, or employee benefit plan;**
- (3) Workers' Compensation (or a similar occupational law); or**
- (4) a government plan (except Medicaid and other public assistance plans), including one set forth by statute (such as Medicare).**

POLICY APPLICATION (please print or type)

which, upon acceptance and approval by **NATIONWIDE LIFE INSURANCE COMPANY -- Columbus, Ohio 43216**, will

become a part of **SPECIFIED HAZARD INSURANCE POLICY NUMBER : 6AJXS28091700**

1. Name of Plan Sponsor: BOX ELDER SCHOOL DISTRICT
(Group's Name)

Permanent Mailing Address: 960 SOUTH MAIN STREET, BRIGHAM CITY, UT, 74302
(Street) (City) (State) (Zip) (County)

2. Policy Term: The policy term starts at 12:01 a.m. on 8/1/2017, which is the effective date and ends at 12:01 a.m. on 8/31/2018, which is the termination date.

3. Covered Activities

For each class of persons, covered activities are as described below.

Class	Description of Activities
1 & 2	All activities, excluding high school football
3 & 4	All activities between the last day of the school year commencing during the policy period and the first day of the following school year.
5 & 6	Participating in or attending any Policyholder sponsored activity, excluding high school football; or while traveling to or from the Insured Person's residence and the Policyholder's premises on days when the Insured Person has regularly scheduled classes or work and within one hour of the scheduled start of or dismissal from the scheduled class or work or at any other time if traveling by transportation furnished or approved by the Policyholder.
7, 8, 9 & 10	Practice or play of football in accordance with the rules of the state high school athletics authority. Group or team travel supervised by the Policyholder to or from a practice or play is covered if in a vehicle furnished or approved by the Policyholder.

4. Maximum Benefit Amounts -- the word "None" means the benefit is not included.

Benefit Provisions		Maximum Benefit Amounts
		Classes 1, 3, 5, 7 & 9
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$100,000.00 overall maximum for any one accident.		
	Death	\$10,000
	Specific Loss (Face Amount)	\$10,000
MEDICAL EXPENSE - Accident		
	Deductible	\$0
	Overall Maximum	\$25,000
The ACCIDENT MEDICAL EXPENSE BENEFIT is modified as follows:		
1) The deductible is reduced by amounts paid by Other Insurance.		
2) Medically necessary professional ambulance service is a Covered Expense.		
3) Covered Expenses does not include Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care and Durable Medical Equipment.		
4) The following Covered Expenses limitations apply. Limitations are per Insured per Injury, unless otherwise specified.		
Office Use Only: LOW		
Covered Expenses		Covered Expense Limitations
Inpatient Hospital Services		
Room & Board – Semi-Private or Private		Maximum \$150 per day

Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum \$600 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	75% of R&C
Emergency Room Services (including use of the emergency room and supplies)	Maximum \$150 if rendered within 72 hours of Injury
Physician Services	
Physician Non-Surgical Services	Maximum \$40 for the first visit, and \$25 for each subsequent visit, limited to one visit per day
Physician Surgical Services, Inpatient or Outpatient	Maximum \$1,000 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum \$200
Assistant Surgeon	20% of Physician Surgical Maximum
Anesthetist Services [(not including supervision of an anesthetist)	20% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum \$1,000
X-Ray Services	Maximum \$200 for Outpatient
Diagnostic Imaging Services	Maximum \$300 for Outpatient
Laboratory Services	Maximum \$50 for Outpatient
Combined Ground and Air Ambulance Services	Maximum \$300
Orthopedic Braces and Appliances	Maximum \$75
Dental Services	Maximum \$10,000
Outpatient Physical Therapy	Maximum \$30 for the first visit, and \$20 for each subsequent visit for a maximum of 5 visits, limited to one visit per day
Prescription Drugs	Maximum \$75
R&C = Reasonable and Customary Charges	

4. Maximum Benefit Amounts -- the word "None" means the benefit is not included.

Benefit Provisions		Maximum Benefit Amounts
		Classes 2, 4, 6, 8 & 10
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$100,000.00 overall maximum for any one accident.		
Death		\$10,000
Specific Loss (Face Amount)		\$10,000
MEDICAL EXPENSE - Accident		
Deductible		\$0
Overall Maximum		\$25,000
The ACCIDENT MEDICAL EXPENSE BENEFIT is modified as follows:		
1) The deductible is reduced by amounts paid by Other Insurance.		
2) Medically necessary professional ambulance service is a Covered Expense.		
3) Covered Expenses does not include Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care and Durable Medical Equipment.		
4) The following Covered Expenses limitations apply. Limitations are per Insured per Injury, unless otherwise specified.		
Office Use Only: HIGH		
Covered Expenses		Covered Expense Limitations
Inpatient Hospital Services		
Room & Board – Semi-Private or Private		80% of R&C

Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum \$1,200 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	100% of R&C
Emergency Room Services (including use of the emergency room and supplies)	Maximum \$300 if rendered within 72 hours of Injury
Physician Services	
Physician Non-Surgical Services	Maximum \$60 for the first visit and \$40 for each subsequent visit , limited to one visit per day
Physician Surgical Services, Inpatient or Outpatient	Maximum \$1,200 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum \$400
Assistant Surgeon	25% of Physician Surgical Maximum
Anesthetist Services [(not including supervision of an anesthetist)	25% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum \$1,200
X-Ray Services	Maximum \$600
Diagnostic Imaging Services	Maximum \$600
Laboratory Services	Maximum \$300
Combined Ground and Air Ambulance Services	Maximum \$800
Orthopedic Braces and Appliances	Maximum \$140
Dental Services	Maximum \$10,000
Outpatient Physical Therapy	Maximum \$60 for the first visit and \$40 for each subsequent visit , for a maximum of 5 visits
Prescription Drugs	Maximum \$200
R&C = Reasonable and Customary Charges	Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care

5. Premium Rates by Class of Eligible Persons

Class	Eligible Persons	Premium per Participant per Year
		Medical Expense Excess Plan
1	Students and employees on whose behalf the required premium contribution is made for Low Option 24-Hour coverage.	As stated in the brochure
2	Students and employees on whose behalf the required premium contribution is made for High Option 24-Hour coverage.	As stated in the brochure
3	Students on whose behalf the required premium contribution is made for Low Option Summer Only coverage.	As stated in the brochure
4	Students on whose behalf the required premium contribution is made for High Option Summer Only coverage.	As stated in the brochure
5	Students and employees on whose behalf the required premium contribution is made for Low Option At-School coverage.	As stated in the brochure

6	Students and employees on whose behalf the required premium contribution is made for High Option At-School coverage.	As stated in the brochure
7	Student members of the High School Football team on whose behalf the required premium contribution is made for full football season Low Option coverage.	As stated in the brochure
8	Student members of the High School Football team on whose behalf the required premium contribution is made for full football season High Option coverage.	As stated in the brochure
9	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football Low Option coverage.	As stated in the brochure
10	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football High Option coverage.	As stated in the brochure

Participant
program

The minimum premium per policy term is \$175.00.

6. The policy is to cover all eligible persons..

7. It is understood and agreed that the premium will be paid entirely as agreed between the Plan Sponsor and the Company.

(Previous Policy Number)

BY _____
(Signature of Applicant)

(Date)

(Printed Name and Title of Applicant)

K & K Insurance Group, Inc. 13-0090572
(Agent's Signature and Number)
GR-9050

960 SOUTH MAIN STREET
BRIGHAM CITY, UT, 74302
(Address of Applicant)

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.

CLAIMS INFORMATION

When must we receive notice? Written notice of claim must be given within 30 days after a covered loss occurs or expense starts or it must be given as soon as reasonably possible. The notice must be sent to the servicing group claims office, our Home Office, or to one of our agents. It should include your policy number and the name of the insured.

How are claim forms obtained? We will send forms to persons who ask for them within 15 days after notice of claim is given. If we do not, written proof (including the event, nature, and extent of loss) may be sent to us without using our forms. This proof must meet the terms of the next paragraph.

When must we receive proof of loss? Written proof must be given to us: (1) within 90 days after the end of any period of disability or hospital confinement for which claim is made; or (2) within 90 days after the date of loss on any other claim.

If it is not reasonably possible to give such proof, it should be given as soon as reasonably possible; but no later than one year from the time it is otherwise due. The one year limit is waived if the insured is legally incapable of giving such proof.

When will we pay claims? First we need written proof of loss. Then all benefits due the insured for loss of time because of total disability will be paid monthly as long as we are liable. Any balance not paid when our liability ends will be paid as soon as we receive proper written proof.

Benefits due for other losses will be paid when we receive proper written proof.

To whom will we pay claims? We will pay loss of life benefits to the insured's designated beneficiary in effect at the time of payment. If none is then in effect, or if the beneficiary dies first, we will pay the benefits to the insured's estate or, at our option, to one or more of the first surviving class of the following classes of successive preference beneficiaries: the insured's surviving spouse, children, parents, or brothers and sisters. This will, to the extent paid, release us from further liability. Other benefits will be paid to the insured except that those unpaid at death may, at our option, be paid to either the insured's estate or beneficiary.

If the insured is a minor or is not competent to give a valid release, we may pay an amount otherwise payable to the insured to his or her parents, guardian, or to a person supporting the insured.

If payment is to be made to the insured's estate or to a beneficiary who is either a minor or is not competent to give a valid release, we may pay up to \$1,000 to someone related to either the insured or to his or her beneficiary by blood or marriage whom we consider to be entitled to the payment. Such payment made by us in good faith will fully discharge us to the extent of the payment.

We may pay covered expenses to the hospital or person providing the service, unless the insured states otherwise in writing by the time proofs of loss are filed. It is not required that a service be provided by any one hospital or person.

How may the beneficiary be changed? The insured may change his or her beneficiary. The beneficiary's consent is not needed unless the designation is irrevocable. Changes may be made during the insured's lifetime by written notice to us at our Home Office.

A change will take effect when the notice is signed, whether or not the insured is living when we receive it. The change will not prejudice a payment made or action taken by us before we receive it at our Home Office.

Can a physical exam be required? Yes. We have the right to have a doctor examine a person whose condition is the basis of a claim. This may be done as often as is reasonably necessary while a claim is pending. This will be at our expense.

Is there a free choice of a doctor? Yes. The insured will have a free choice of a doctor. The doctor-patient relationship will be maintained.

What if there is a common accident? If an insured and his or her beneficiary die from the same accident without enough evidence that they died other than at the same time, the insured's benefits will be paid as if he or she died last.

GENERAL INFORMATION

What is your agreement with us? How can it be changed? The policy (with the application and attached papers) and the individual enrollment forms, if any, make up the entire legal contract between you and us. All statements made by you or by an insured are representations and not warranties. Such statements will not affect coverage or be used in defense of a claim unless they are in a written application or individual enrollment form which has been signed by the insured. A copy of the statement must be furnished to the insured or to his or her beneficiary, if any. No change in the contract will be valid unless it is in an amendment signed by either our President or Secretary and accepted (signed) by you.

The contract may be changed at any time by mutual agreement between you and us. The consent of an insured or others having a beneficial interest is not required. A change will not affect a claim which occurs before the change is made.

No agent may: (1) change the contract in any way; (2) accept premium in arrears; or (3) extend a premium due date.

What if the contract does not conform with state laws? If, on its effective date, any provision of the contract is in conflict with a law of the state in which it is delivered, such provision is amended to conform to the law's minimum requirements.

What about new eligible persons? They must be added to the groups or classes for which they are eligible.

Are individual certificates used? When the law requires it, we will provide a supply of these forms to be given to all insureds. The certificates will contain the main features of the contract which relate to the insured. They are not contracts.

What kind of records must be kept? Records must be kept which will show, at all times, the names of the insureds and the details of each insured's insurance.

We have the right to inspect these records at any reasonable time to the extent that they relate to the contract.

What kind of reports must be made? Those that we need to administer and rate the contract.

What if an eligible person is not recorded or reported? Coverage will not be denied if failure to record or to report an eligible person for insurance is the result of a clerical error.

May benefits be assigned? Yes; but only medical expense benefits, if any. We are not bound by an assignment until we receive it in writing at either the servicing group claims office or our Home Office. We are not responsible for its validity.

When can legal action be brought? Legal action to recover under the contract can be brought only after 60 days and before 3 years (5 years if a Kansas contract or 6 years if a South Carolina contract) from the time written proof of loss must be given.

Is this a Workers' Compensation contract? No. It does not replace or affect any requirement for coverage by Workers' Compensation or a similar occupational law.

NATIONWIDE LIFE INSURANCE COMPANY



Secretary



President

Countersigned by _____

(LICENSED RESIDENT AGENT)

SPECIFIED HAZARD ACCIDENT INSURANCE POLICY RIDER

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this rider to

THE PLAN SPONSOR REFERED TO ON THE FIRST
PAGE OF THE POLICY TO WHICH THIS RIDER IS ATTACHED
AND MADE A PART THEREOF

POLICY NUMBER: 6AJXS28091700

The effective date of this rider is the effective date of the policy to which this rider is attached.

The policy is amended as described below. All other terms remain unchanged.

The following paragraph is added as a second paragraph under the section entitled **PREMIUM** on page two of the policy:

When experience on a case is available to the company under a policy or policies issued by the company or issued by another insurer, the premium rates and benefit limits may be adjusted, on a prospective basis, to produce anticipated experience for the case approximating the anticipated loss ratio.

NATIONWIDE LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Kit C. Walker". The signature is written in a cursive, flowing style.

President