Pacific Educators
Insurance Services

- Please note that there are four pages to the brochure (not including this one)
- You may apply online with a credit card here www.peinsurance.com/signup OR:
- If you would like to apply with a paper application, the third page below is an actual application that you can print and complete by hand, **or you may complete on computer and print**. DO NOT SEND CASH. Make check or money order payable to Pacific Educators and mail to:

Pacific Educators
2808 E. Katella Ave., Suite 101
Orange, CA 92867

- The last page is a **FREE Prescription Drug Card Program** you can print and take to a Pharmacy to help anyone lower their prescription drug costs.
- If you have any questions, please do not hesitate to contact us directly (800) 722-3365 or email at studentinsurance@peinsurance.com

2016-2017 STUDENT INSURANCE PLANS

WE RECOMMEND 24-HOUR-A-DAY COVERAGE

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident insurance plans to cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- If you have other insurance, these plans can help offset the deductibles and coinsurance for those plans.
- If you have no other insurance, these plans will provide basic coverage.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	BECOMES EFFECTIVE THE DATE PREMIUM PAYMENT IS RECEIVED BY THE COMPANY OR ITS REPRESENTATIVE (but not prior to the opening day of school).
✓	✓	PROVIDES COVERAGE DURING THE HOURS THAT SCHOOL IS IN REGULAR SESSION.
✓		PROVIDES 24-HOUR-A-DAY PROTECTION.
✓	✓	PROVIDES COVERAGE DURING THE TIME NECESSARY FOR TRAVEL BETWEEN THE INSURED'S HOME AND THE BEGINNING OR END OF REGULAR SCHOOL SESSIONS.
✓	✓	PROVIDES COVERAGE WHILE PARTICIPATING IN (OR ATTENDING) ACTIVITIES ORGANIZED, SPONSORED AND SUPERVISED BY THE SCHOOL. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	COVERAGE EXPIRES AT THE CLOSE OF THE REGULAR SCHOOL TERM. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		COVERAGE CONTINUES WITHOUT INTERRUPTION ALL SUMMER until school re-opens for the following term.

OPTIONAL FOOTBALL COVERAGE BEGINS ON THE DATE OF PREMIUM RECEIPT BY THE COMPANY, ITS REPRESENTATIVES OR SCHOOL OFFICIALS, BUT NOT PRIOR TO THE FIRST OFFICIAL DATE OF PRACTICE; AND CONTINUES THROUGH THE DATE OF THE LAST OFFICIAL GAME OF THE CURRENT SEASON INCLUDING PLAYOFFS.

To File A Claim: Report accidents to the school official. Simplified forms will be furnished through the principal's office (during vacation time contact the administrators of the plan). COMPLETED PROOF OF LOSS AND ACCUMULATED BILLS MUST BE RECEIVED BY GUARANTEE TRUST LIFE INSURANCE COMPANY WITHIN 90 DAYS.

Accident Insurance

24-Hour-A-Day Coverage

24-Hour-A-Day Protection for each Covered Accident

Protects your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

✎ At home ✎ At play ✎ At school ✎ On vacation ✎ Scouting, camping etc. ✎ During covered travel

✎ While engaged in sports, except those specifically excluded or for which optional coverage is required*

***See OPTIONS for available optional sports coverage, if any.**

School-Time Coverage

Your child is protected while attending regular school sessions. Also covered is travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees. Optional coverage may be required for interscholastic sports. See OPTIONS for available optional sports coverage, if any.

Blanket Accident insurance is issued on Form Series GP-1200 by Guarantee Trust Life Insurance Company. This product, and its features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. This brochure is a brief description of the coverage. For complete details of coverage please contact the agent administering the program.

CA-E-16-17

2016-2017 STUDENT INSURANCE PLANS

What's Covered? *Up to* $50,000.00 as described under Coverage and Benefits *for:*

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS FROM ACCIDENTAL BODILY INJURY RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES
- COVERED MEDICAL EXPENSE WHICH BEGINS WITHIN 120 DAYS OF THE ACCIDENT AND IS INCURRED WITHIN 52 WEEKS OF THE DATE OF FIRST MEDICAL TREATMENT

Your school district does not carry medical or dental insurance for your child should he/she be injured on school premises while under school grounds jurisdiction, or through school sponsored activities. However it does make this plan available to you, for your consideration.

Esto es para avisarle que su Districto de la Escuela no tiene aseguranza medica ni dental para su nino/nina si se lastima en el terreno de la esquela aunque haiga supervisor en las actividades. Pero se puede tener un plan para su consideracion. Este plan de aseguranza es voluntario. Usted debe saber que la ley del estado requiere cualquier estudiente que participe en deportes escolares debe tener aseguranza adecuada para medico antes de paticipar en deportes.

COVERAGE & BENEFITS

BENEFITS ARE PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW

BENEFITS PER ACCIDENT		HIGH OPTION	LOW OPTION
HOSPITAL & GENERAL NURSING CARE	**ROOM AND BOARD**, Per Day	Semi-private	$300
	INTENSIVE CARE, Per Day	$1,200	$600
HOSPITAL MISCELLANEOUS EXPENSE	During Hospital Confinement or for out-patient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, x-rays, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies	$3,000	$1,500
HOSPITAL EMERGENCY CARE		$300	$150
DOCTOR'S FEES FOR SURGERY	In accordance with the Surgical Schedule	$270 Unit Value	$175 Unit Value
ANESTHESIA SERVICES	Percent of Surgical Fee	25%	25%
ASSISTANT SURGEON	Percent of Surgeon's Fee	25%	25%
DOCTOR'S VISITS One visit per day. Does not apply when related to surgery	First Visit	$120	$60
	Subsequent Visits	$60	$30
	Including Physical Therapy which is limited to **9** visits.		
ORTHOPEDIC APPLIANCES	Includes Braces and Crutches	$100	$50
CASTS	Non-surgical cases	$100	$50
AMBULANCE EXPENSE		100% of Reasonable & Customary	$250

BENEFITS PER ACCIDENT		HIGH OPTION	LOW OPTION
OUTPATIENT IMAGING PROCEDURES Including X-rays and Interpretation	**FRACTURE OR DISLOCATION**	$500	$250
	NO FRACTURE OR DISLOCATION	$100	$50
	MAGNETIC RESONANCE IMAGING (MRI) or **CAT SCAN**	$900	$500
PRESCRIPTION DRUGS		100% of Reasonable & Customary	$50
DENTAL TREATMENT	For Injury to Teeth - **PER TOOTH**	$300	$150
EYEGLASS REPLACEMENT EXPENSE	For broken eyeglasses or lenses resulting from an Injury requiring medical treatment	$150	$100
RE-AGGRAVATION OR RE-INJURY OF A PRE-EXISTING CONDITION		$500	$500
OTHER BENEFITS Only one of these amounts, the largest, will be paid for loss resulting from any one Accident	**ACCIDENTAL DEATH** caused by an Injury and occurring within 365 days of covered Accident	$5,000	$5,000
	DISMEMBERMENT caused by an Injury and occurring within 365 days of covered Accident		
	Loss of one hand, one foot or one eye	$5,000	$5,000
	Both hands, feet or eyes	$10,000	$10,000

EXTENDED DENTAL BENEFIT OPTION: For an additional premium the Dental Treatment Benefit will be increased to pay all Reasonable and Customary charges for: examination, diagnoses and x-ray; restorative treatment; endodontics; and oral surgery (not to include periodontics or orthodontics); up to $250 for dental prostheses toward the cost of a bridge, partial denture or denture, or for replacement in kind of previous dental repairs. If during the Benefit Period, the Insured's dentist certifies that treatment must be deferred, the Insurance Company will pay up to a maximum of $100 in lieu of all other dental benefits.

EXCLUSIONS: The Policy does not provide benefits for:

1. Treatment, services or supplies which: are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are determined to be Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the school or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy.
2. Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law. Injury by acts of war, whether declared or not.
3. Injury covered by Worker's Compensation or the Occupational Disease Law.
4. Hernia or slipped femoral capital epiphysis.
5. Injury sustained fighting or brawling, except as an innocent victim.
6. Treatment of sickness or disease in any form, blisters, insect bites, frostbite, heat exhaustion or sunstroke.
7. Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts.
8. Injury sustained while operating, riding in or upon, mounting or alighting from, any two- three- or four wheeled motor/engine driven recreational vehicle or snowmobile or all terrain vehicle (ATV).
9. Injury sustained while participating in or practicing for interscholastic tackle football in grades 9 through 12, including travel, unless optional coverage has been purchased.

EXCESS PROVISION: All Covered Charges over $500 will be considered for payment on an Excess basis if any Other Valid and Collectible Insurance or Plan covers the Insured person. The Company will pay the first $500 in Covered Charges regardless of other insurance.

This is an illustration of your child's benefits. Please keep for your records. This is not a contract. The Master Policy is on file with your school.

Underwritten and Claims Paid by: **GUARANTEE TRUST LIFE INSURANCE COMPANY**, Glenview IL - (800) 622-1993

Administered by: **PACIFIC EDUCATORS, INC.,** 2808 E. Katella Ave., Suite 101, Orange, CA 92867-5299 (714) 639-0962 or (800) 722-3365 Pacific Educators' California License No. - 0429928

2016-17 School Year Application

ONE TIME ANNUAL PAYMENT		
OPTIONS	**HIGH OPTION**	**LOW OPTION**
24-HOUR-A-DAY PLAN **$50,000 Maximum per Injury**		
Grades Pre-K thru 8	❑ $161.00	❑ $75.00
Grades 9 thru 12	❑ $192.00	❑ $92.00
SCHOOL-TIME PLAN **$50,000 Maximum per Injury - High Option** **$25,000 Maximum per Injury - Low Option**		
Grades Pre-K thru 8	❑ $25.00	❑ $11.00
Grades 9 thru 12	❑ $54.00	❑ $24.00
OPTIONAL FOOTBALL COVERAGE (2016 Season Only) Payable in addition to School-Time and 24-Hour **$25,000 Maximum per Injury**		
Grade 9	❑ $80.00	❑ $36.00
Grades 10 thru 12	❑ $177.00	❑ $84.00
EXTENDED DENTAL BENEFIT OPTION	❑ $6.00	

TOTAL $ _____
(Please do not send cash)
MAKE CHECK PAYABLE TO:
PACIFIC EDUCATORS, INC.

NO REFUNDS ARE AVAILABLE

GTL | GUARANTEE TRUST LIFE

PLEASE PRINT CLEARLY

Student's Name _____
First Name Middle Initial Last Name

Date of Birth _____ **Male** ❑ **Female** ❑
Month Day Year

School District _____ **School** _____

Grade _____ **Student's Address** _____

City _____ **State** _____ **Zip** _____

Telephone # _____ **Date of Application** _____

Parent or Guardian's Email Address _____

Signature of Parent or Guardian _____

TO PAY BY CREDIT/DEBIT CARD (fee applies)
PLEASE GO TO:
WWW.PEINSURANCE.COM OR CALL (800) 722-3365

L-06-30

PLEASE REMEMBER TO:

COMPLETE THE APPLICATION FORM AND CHECK THE PLAN AND OPTIONS YOU WANT.

MAKE YOUR CHECK OR MONEY ORDER (PLEASE DO **NOT** SEND CASH) FOR THE TOTAL ENCLOSED PAYABLE AS INDICATED.

MAIL THE APPLICATION WITH YOUR CHECK OR MONEY ORDER TO:

Pacific Educators, Inc.
2808 E. Katella Ave., Suite 101
Orange, CA 92867-5299

PLEASE NOTE: YOUR CANCELED CHECK IS YOUR RECEIPT. IF CANCELED CHECK IS NOT RECEIVED WITHIN 60 DAYS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR.

For faster service you can pay by credit or debit card (fee applies) please visit us online at:
Pacific Educators
www.peinsurance.com
click Products then Students
or call (800) 722-3365

Pacific Educators
FREE Prescription Drug Card

Member: California Student
ID Number: 26291W22ES
Program: UNARxCard
RxBIN: 610709
RxGrp: PFCEDU

Note: Everyone is eligible for this program. There are no age or income restrictions. Each family member must have his/her own card. If you can't print a card have your pharmacy call the Pharmacy Help Line and we will help them process your prescription.

THIS PROGRAM IS NOT INSURANCE
THIS PROGRAM IS A POINT OF SALE DISCOUNT PLAN

INSTRUCTIONS **This card is pre-activated and can be used immediately. Simply print this card and take to any participating pharmacy to receive a discount. You can search pharmacy, pricing information, and FAQ's on the website. We are restricted from disclosing drug pricing over the phone.**
Customer Service (TOLL FREE) 800-726-4232

ATTENTION PHARMACIST **If you need help processing a prescription call our Pharmacy Help Line at Pharmacy Help Line (TOLL FREE) 877-321-6755.**

PROGRAM POWERED BY:

United Networks OF AMERICA UNARx Card

IMPORTANT: PRINT CARD. YOU WILL NEED TO BRING THIS CARD TO THE PHARMACY WITH YOUR PRESCRIPTION.

We are proud to announce that Pacific Educators is now making available a **FREE Prescription Drug Card Program** to help anyone lower their prescription drug costs.

This card can be used with a primary plan and/or on prescriptions not covered by your insurance plan. It also can be used even if you don't have any insurance. The Rx Card Program has no restrictions or participation requirements and is open to anyone.

This Free Prescription Drug Card is pre-activated and can be used immediately.

NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT AN ACCIDENT MEDICAL CLAIM FORM

- The claim form must be completed and signed by the School or School District **and** the injured Member (if the member is a minor, then the Member's parents or guardian should complete and sign the claim form). Please indicate your Policy Number on the claim form. Also, the "HIPPA Authorization To Permit Use and Disclosure of Health Information" must be signed.

- PROOF OF LOSS (COMPLETED CLAIM FORM AND ITEMIZED BILLS) SHOULD BE SUBMITTED **WITHIN 90 DAYS OF THE ACCIDENT**. ADDITIONAL BILLS RELATED TO THE ACCIDENT SHOULD BE SUBMITTED **WITHIN 90 DAYS OF TREATMENT**.

- Please attach itemized bills to the claim form. A balanced due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:

    1) **The date(s) of treatment,**
    2) **The type(s) of service,**
    3) **The diagnosis,**
    4) **The medical provider's name and address**
    5) **The individual charge for each expense**.

- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.

- Return the completed claim form, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements (if applicable) to:

GUARANTEE TRUST LIFE INSURANCE COMPANY
P.O. Box 1148
Glenview, Illinois 60025

- Please indicate which bills have been paid by you. If you prefer our payment to go directly to the medical provider, please notate this on the bills.

- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, School or School District Name, Policy Number, and date of accident.

- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

IMPORTANT:

Please take note that your claim will result in processing delays as the result of not providing us with the following: the completed claim forms, the itemized bills from your medical provider and a copy of your other insurance payment or denial ("Explanation of Benefits") statement.

If you have any questions, please contact our Customer Service Department at (800) 622-1993.

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. _____

IMPORTANT! THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

GUARANTEE TRUST LIFE INS. CO.
P.O. Box 1148
Glenview, IL 60025
(800) 622-1993

ASSIGNMENT OF BENEFITS:

Dr.: _____ Hosp.: _____ Other: _____
Addr: _____ Addr: _____ Addr: _____
_____ _____ _____
City State Zip City State Zip City State Zip

I hereby authorize Guarantee Trust Life Insurance Co. to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee indicated above.

DATE _____ **SIGNATURE OF PARENT OR GUARDIAN** _____
Claimant – if an ADULT

SCHOOL OFFICIAL TO COMPLETE: PLEASE PRINT (PARENT MUST COMPLETE IF A 24 HR. COVERAGE CLAIM IS INVOLVED)

1. **Claimant's FULL NAME** _____ Alternate Name _____ Date of Birth ____/____/____ Grade _____

2. Claimant's Address: Street or RFD_____ City _____ State_____ Zip _____

3. Date of Accident _____ 20_____ Hour _____ AM □ PM □

4. Description of Accident: **(A)** How and where did it occur? _____
_____ (if more space needed, attach separate sheet)
(B) Nature of Injury _____

5. Description of Activity (What was the Claimant doing at time of injury?) _____
If Athletics, name sport _____ Intramural □ Interscholastic □ Other □

6. **(A)** On date of accident what time did school start for this student? _____ AM □ PM □
(B) What time was student dismissed from school? _____ AM □ PM □

7. Has a previous claim been filed for this accident? Yes □ No □

8. **(A)** Name of School Authority supervising Activity _____
(B) Was Supervisor a witness? Yes □ No □
(C) If not, when was accident reported to School Authority? _____

TYPE OF SCHOOL CLAIMANT ATTENDS: Elementary □ Jr. High □ High □ Other □

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of Official _____ Title _____

PARENT TO COMPLETE (OR CLAIMANT, IF AN ADULT) IN ORDER FOR CLAIM TO BE PROCESSED.

9. Do you have other insurance, which covers this condition, either group, individual, automobile medical or liability? Yes □ No □
If Yes, give Company Name and Phone Number _____ Policy # _____

10. Parents Name: Father _____ Mother _____
Employer's Name: _____ _____
Employer's Address: _____ _____

I certify that the above information is correct to the best of my knowledge and belief.

SIGNATURE _____ **DATE** _____ **ADDR** _____
(Parent/Guardian or claimant if an Adult) _____

For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator located at the facility named below to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

Facility Name: _____

Address: _____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

_____

(Print Please) Name of Patient — Date of Birth

_____

Signature of Patient — Date

_____

(Please Print) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient

_____

Signature of Authorized Representative or Next of Kin — Date