



AMERICAN SENTINEL INSURANCE COMPANY

Mailing Address: P.O. Box 61140, Harrisburg, PA 17106-1140

Located at 2407 Park Drive in Harrisburg

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APPLICATION FOR ATHLETIC TEAM COVERAGE

NAME OF TEAM OR LEAGUE _____

ADDRESS _____

NAME OF PERSON APPLYING _____, HOLDER

EFFECTIVE DATE _____ EXPIRATION DATE _____

SPORT _____

Please complete the section below based on the specific rates listed on the reverse side of this application. Team rates cover normal season of 3 to 7 months. Additional adjusted premium will be based on exposure. If 4 or more teams are covered in any league, a 10% discount may apply.



NUMBER OF TEAMS _____, AGES 8-12 @ \$ _____ = \$ _____

NUMBER OF TEAMS _____, AGES 13-15 @ \$ _____ = \$ _____

NUMBER OF TEAMS _____, AGES 16-18 @ \$ _____ = \$ _____

NUMBER OF TEAMS _____, ADULTS @ \$ _____ = \$ _____

***Football and T-Ball, please indicate specific age bracket as shown on the other side.**

ADDITIONAL PARTICIPANTS

NUMBER OF PARTICIPANTS _____, AGES 8-12 @ \$ _____ = \$ _____

NUMBER OF PARTICIPANTS _____, AGES 13-15 @ \$ _____ = \$ _____

NUMBER OF PARTICIPANTS _____, AGES 16-18 @ \$ _____ = \$ _____

NUMBER OF PARTICIPANTS _____, ADULTS @ \$ _____ = \$ _____

CHEERLEADERS

_____, AGES 8-12 @ \$ 1.25 = \$ _____

_____, AGES 13-15 @ \$ 2.00 = \$ _____

_____, AGES 16-18 @ \$ 3.60 = \$ _____

_____, ADULTS @ \$ 6.45 = \$ _____

Deduct 10% if 4 or more teams

***TOTAL PREMIUM ENCLOSED = \$ _____**

AGENT

SIGNATURE OF HOLDER

Signature of Agent:

Printed Name:



**AMERICAN SENTINEL INSURANCE COMPANY
HARRISBURG, PENNSYLVANIA**

APPLICATION – RATE SHEET FOR ATHLETIC TEAM ACCIDENT INSURANCE

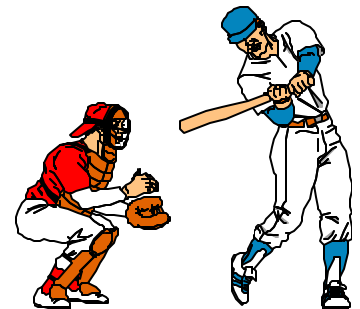
ACCIDENTAL DEATH & DISMEMBERMENT.....	\$10,000.00
PHYSICIAN, SURGEON & HOSPITAL INDEMNITY – Aggregate Maximum Scheduled Amount Payable Per Person Per Accident.....	\$10,000.00

TEAM PREMIUM

Baseball		Softball		T-Ball	
\$ 61.00	Ages 8-12	\$ 56.00	Ages 8-12	\$48.00	Ages 5-8
\$123.00	Ages 13-15	\$ 98.00	Ages 13-15		
\$163.00	Ages 16-18	\$122.00	Ages 16-18		
\$344.00	Adults (Over Age 18)	\$299.00	Adults (Over Age 18)		

Football (Team comprised of up to 33 Participants)
\$497.00 Midget League Football Teams only Ages 8-13
Additional Participants \$15.00 each

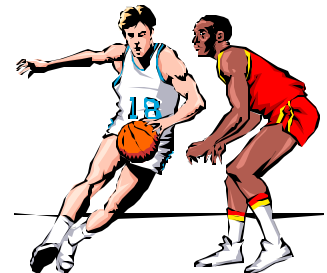
Wrestling (Team comprised of up to 40 Participants)
\$197.00 Ages 8-12 \$ 4.95 each
\$360.00 Ages 13-15 **OR** \$ 9.00 each
\$420.00 Ages 16-18 \$10.50 each
\$560.00 Adults (Over Age 18) \$14.00 each



Soccer (Team comprised of up to 25 Participants)
\$190.00 Ages 8-12 \$ 7.60 each
\$205.00 Ages 13-15 **OR** \$ 8.20 each
\$315.00 Ages 16-18 \$12.60 each
\$540.00 Adults (Over Age 18) \$21.60 each

Ice Hockey, Field Hockey, Deck Hockey or Street Hockey (Team comprised of up to 12 Participants)
\$190.00 Ages 8-12 \$ 7.60 each
\$205.00 Ages 13-15 **OR** \$ 8.20 each
\$315.00 Ages 16-18 \$12.60 each
\$540.00 Adults (Over Age 18) \$21.60 each

Basketball (Team comprised of up to 12 Participants)
\$ 49.00 Ages 8-12 \$ 4.00 each
\$ 79.00 Ages 13-15 **OR** \$ 6.60 each
\$152.00 Ages 16-18 \$12.65 each
\$204.00 Adults (Over Age 18) \$17.00 each



Cheerleaders
\$1.25 each Ages 8-12
\$2.00 each Ages 13-15
\$3.60 each Ages 16-18
\$6.45 each Adults

Each team is comprised of up to a specified number of participants. If extra participants are to be covered, use the individual rates as listed above for the additional participants.

TO ALL PARTICIPANTS:

This is a digest of the insurance protection provided for those participating in (on) the league (Team). You should treat this protection as extra insurance coverage. The benefits provided by this policy are payable in addition to any other insurance, but note that benefits are payable in accordance with a schedule. Present injury claims to your hospitalization insurance carrier in addition to American Sentinel Insurance Company.

DIGEST OF BENEFITS

POLICY COVERS: Injuries received by the insured coaches, managers, mascots, cheerleaders, scorekeepers and players while participating in a regularly scheduled game or regularly scheduled practice of the policyholder or traveling directly to or from such game with other members of the team as a group.

EXCLUSIONS: THIS POLICY DOES NOT COVER any loss caused by or resulting from: (1) Suicide or any attempt thereat while sane or self destruction or any attempt thereat while insane; (2) riding as a passenger or otherwise in any vehicle or device for aerial navigation; (3) the expense of replacing eyeglasses, contact lenses or prescriptions therefore; (4) war or any act of war (declared or undeclared).

BENEFITS:

LOSS OF LIFE ACCIDENT INDEMNITY: When injury results in loss of life of an Insured, the Company will pay the Loss of Life Accident Indemnity stated in the Schedule (\$10,000.00).

ACCIDENT MEDICAL, SURGICAL, HOSPITAL, MISCELLANEOUS BENEFITS, ALLOCATED, AS SET FORTH BELOW, UP TO AN AGGREGATE PER PERSON PER ACCIDENT OF \$10,000.00.

A. **ACCIDENT MEDICAL EXPENSE BENEFIT:** When injury shall, commencing within 52 weeks from the date of the accident, require nonsurgical treatment by a duly qualified physician or dentist, the Company will pay Duly Qualified Physician and Dentist Indemnity at the rate of \$25.00 for each required treatment but not to exceed 30 such treatments as a result of any one accident.

When injury to sound, natural teeth shall require a dental operation to save a tooth by removing the contents of its root canal, a tooth implant, or an artificial replacement for a tooth which had to be removed, the Company will pay Dental Expense Indemnity at the rate of \$175.00 per tooth.

B. **X-RAY EXAMINATION INDEMNITY BENEFIT:** When injury shall, commencing within 52 weeks from the date of the accident, require X-ray examination including mammographic examination recommended by a duly qualified physician, the Company will pay \$60.00 X-Ray Expense Indemnity for one or more X-Rays performed on the same date.

C. **SURGICAL OPERATION INDEMNITY BENEFIT:** When injury shall, commencing within 52 weeks from the date of the accident, require an operation named in the schedule and such operation is performed by a duly qualified physician, the Company will pay indemnity in the amount designated in the Schedule. In the event of cutting operations and treatment of fractures not specified in the Schedule, the Company will pay the indemnity set opposite an operation of comparable severity.

SCHEDULE OF OPERATIONS

Suturing Surface Wounds.....	\$ 80.00
Suturing Tendons or Ligaments	
Single.....	\$ 80.00
More Than One.....	\$100.00
Eye	
Any Cutting Operation.....	\$110.00
Removal of Eyeball.....	\$120.00
Nerve	
Stretching or Suturing.....	\$125.00
Skin Grafting	
Four Square Inches or Less.....	\$200.00
More Than Four Square Inches.....	\$450.00
Arthroscopic Surgery.....	\$250.00

	<u>By Closed Reduction</u>	<u>By Open Operation</u>
Complete Dislocation		
Hip or Knee Joint.....	\$155.00	\$215.00
Shoulder Joint.....	\$155.00	\$215.00
Elbow or Ankle Joint.....	\$155.00	\$215.00
Complete Fracture of Bones		
Skull.....	\$300.00	\$450.00
Femur.....	\$245.00	\$360.00
Tibia & Fibula, Both.....	\$245.00	\$360.00
Tibia & Fibula, Either.....	\$145.00	\$200.00
Spine.....	\$260.00	\$475.00
Humerus.....	\$250.00	\$375.00
Radius & Ulna, Both.....	\$250.00	\$375.00
Radius & Ulna, Either.....	\$150.00	\$200.00
Sternum.....	\$100.00	\$200.00
Coccyx.....	\$100.00	\$175.00
Finger or Toe.....	\$ 85.00	\$125.00
More Than One.....	\$125.00	\$175.00
Rib or Ribs.....	\$125.00	\$175.00
Lower Jaw.....	\$125.00	\$150.00
Pelvis.....	\$325.00	\$450.00
Bones of Hand or Foot (Except Fingers or Toes).....	\$100.00	\$175.00
Clavicle.....	\$150.00	\$200.00
Bones of Face.....	\$100.00	\$125.00
Patella.....	\$200.00	\$375.00
Scapula.....	\$200.00	\$375.00

D. **DAILY HOSPITAL INDEMNITY PAYABLE:** When injury shall, commencing within 52 weeks from the date of the accident require confinement in a lawfully operated hospital as a resident patient, the Company will pay to the Insured Hospital Indemnity at the rate of \$85.00 per day beginning with the first day of hospital confinement, but not to exceed 100 days as the result of any one accident.

E. **HOSPITAL SERVICES EXPENSE INDEMNITY:** When injury shall, commencing within 52 weeks from the date of the accident, require any of the hospital services listed below, the Company will pay indemnity in the amount set opposite each service, but not to exceed one such service as a result of any one accident:

Emergency Room.....	\$55.00	Casts, Splints, and Braces.....	\$50.00
Operating Room.....	\$70.00	Wheel Chair.....	\$30.00
Anaesthetic.....	\$75.00	Crutches.....	\$30.00
Blood Transfusion.....	\$40.00	Miscellaneous Hospital Expense.....	\$30.00

F. **AMBULANCE EXPENSE INDEMNITY:** When injury shall require the service of an ambulance to or from a hospital, or duly qualified physician's office or from the scene of an accident, the Company will pay \$150.00 Ambulance Fee Indemnity but not to exceed one such service as a result of any one accident.