St. Joan of Arc School

230 South Law Street
Aberdeen, Maryland, 21001

Grounded in Faith, Focused on the Future

Phone (410)272-1387
Fax (410)272-1959
school@stjoanarc.org

September 3, 2020

Dear SJA Families,

Thank you so much to all SJA families! Despite the restrictions this year, we have had an awesome start to 2020-21. Please continue to reach out to myself, Mrs. Tokarski, or the teachers with your questions or concerns. We are partners in providing an excellent Catholic school education to your children!

All families should have received two name signs to hang from their car mirror. Displaying your last name allows us to dismiss more quickly. **Please also display your name tag in your car upon arrival**. Since we have to confirm that the wellness survey is completed for each child this would be helpful. It is difficult to see through the windows and masks!

Parents, please remember to **please complete all checklist items in School Admin** for each student. If your student is returning remotely, you need not complete the Acknowledgement or Assumption of Risk form at this time. These forms should be completed if the student attends in-person.

Please remember to join the online meeting for Back to School Night tonight for grades 1 through 5 and tomorrow evening for middle school. Schedule is as follows:

- Wednesday, Sept. 2nd 6:30-7:30PM Grades 1 and 2
- Wednesday, Sept. 2nd 7:30-8:30PM Grades 3, 4 and 5
- Thursday, Sept. 3rd 7-8PM Middle School

A reminder to students: during instruction, they must follow the **Video Conferencing Expectations** (attached). It is very important that students behave as they would in the classroom, particularly to listen and not have a side conversation during instruction. The teacher will give the student a warning if they are having difficulty following the guidelines; a reflection will follow if the behavior continues. We want students who are learning remotely to receive instruction. If parents have a question/concern, they should email the teacher at another time after class.

You are still able to purchase the SJA 2019-2020 Yearbook. Price: $19.95 Go to commpe.pictavo.com (Enter “Maryland”; Enter “Aberdeen”; Enter “St. Joan of Arc School”. The delivery is later this year.

There are many questions regarding this year’s volunteer hours. The number of hours required will depend upon the events and fundraisers that we are able to hold this school year. We need to ensure

that there will be enough opportunities to complete the hours. We hope that we will have fewer restrictions and more events as the year progresses and will keep you posted.

St. Joan of Arc Parish is re-opening the Good Samaritan ministry on Saturdays. The food pantry is in need of peanut butter and jelly. If you would like to help feed the poor by donating these items, please send them in with your child.

The St. Joan of Arc Home School Association is the formal association binding the parents, students and teachers more closely and supports all efforts of St. Joan of Arc School. HSA is in need of some volunteers to fill the vacant positions of Treasurer, Events Coordinator, and Member at Large. For more information, please contact HSA President, Mrs. Jamie Ayd. theayds@verizon.net Thank you for your help!

The Office of Risk Management is offering student accident insurance for the safety and protection of our students. Similar to past years, our insurance program is a two-tiered approach: a voluntary paid basic plan providing up to $25,000 coverage purchased by the students' families, and a catastrophic plan that has a $5,000,000 coverage limit and a $25,000 deductible, provided by the AOB for those schools participating in the AOB Property & Casualty insurance program. Attached is a brochure if you are interested.

Due to restrictions from the State of Maryland, the **Extended Care Program will have limited space this year**. Priority will be given to children of parents who need care every day and are required to leave home for work. We have very few spots left! Attached are the registration form and the health form which must be submitted in order to secure a spot for your child. Please contact Sandra Fink for more information. sfink@stjoanarc.org

Peace and all good,

Mrs. Ginger Bahr, Principal
St. Joan of Arc School
230 South Law Street
Aberdeen, Maryland 21001
Phone (410)272-1387
vbahr@stjoanarc.org

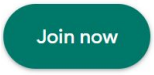
Video Conferencing: Student Expectations

Before you start

- ❑ Gather your materials: device, papers, pencil/pen.
- ❑ Find a spot without distractions.
- ❑ General expectation: If it wouldn't be appropriate in the classroom, it isn't appropriate in the meeting.
- ❑ Be on time.

Important privacy issues

- ❑ When you participate in a video meeting, you are providing a "window" into your home.
- ❑ Please think about what is behind you and what may come into view during the meeting.
- ❑ Do not screenshot or record anything during the meeting. Please refer to the handbook for further information.



Joining the meeting

- ❑ Click on the link or call the phone number.
- ❑ Mute yourself by clicking on the bottom of the screen.

Using your mic

- ❑ Unmute yourself when you want to talk, then mute again.
- ❑ Select the mic button on the bottom of your screen
- ❑ Pause for a moment to allow for the audio delay.
- ❑ Talk normally.
- ❑ Don't have side conversations. The mic will pick up other noises in the room.

Using your camera

- ❑ Select the camera button on the bottom of your screen to turn it on and off.
- ❑ Try to look at the camera, not your screen.
- ❑ If your camera is off, you might need to say who you are when you talk.

Stay engaged

- ❑ Nod or do "thumbs up" when others are talking.
- ❑ Try not to do anything else when you're participating in the meeting.
- ❑ Use the chat, but think before you type, just like you would think before you talk.
- ❑ Raise your hand to share ideas, and the teacher will ask you to unmute yourself.

Keeping track

- ❑ Take notes on paper or in a doc during the meeting.

Some final thoughts

- ❑ Always behave as if your camera and mic are on.
- ❑ Be respectful and patient.

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EXTENDED DAY PROGRAM 2020 - 2021

The Extended Day Program is in operation on regular school days including scheduled half days and AOB Professional days as long as the 7+ attendance is reached. Parents will be billed monthly. We provide this service at a lower cost than most programs for parent convenience. The program operates under a letter of compliance from the State of Maryland and therefore meets all MSDE requirements. ***NOTE: A Registration form and Emergency Form are mandatory. These must be completed and submitted before the child is allowed to attend Extended Care. Your child cannot be admitted to Extended Care without these forms. A $50 deposit is required for registration for any care other than Drop-In. Thank you.**

The **monthly** costs for the Extended Day Program are:

	1 Child	2 Children	3 Children
7:00-8:00AM	$ 120.	$ 210.	$ 280.
3:10-4:10PM	$ 120.	$ 210.	$ 280.
7:00-8:00AM and 3:10-4:10PM	$ 185.	$ 275.	$ 345.
3:10-6:00PM	$ 210.	$ 310.	$ 390.
Drop-in rates per hour	$ 7.	$ 12.	$ 17.

EXTENDED DAY PROGRAM REGISTRATION FORM

Father/Guardian_____ Primary # _____

Address_____ Secondary # _____

e-mail address _____

Mother/Guardian_____ Primary # _____

Address_____Secondary # _____

e-mail address _____

NAMES OF CHILDREN GRADE IN SEPTEMBER

_____ _____

_____ _____

_____ _____

PLEASE INDICATE HOW YOU WILL BE USING THE EXTENDED CARE PROGRAM:

☐ Before School Care	☐ Monthly	☐ Drop-In
☐ After School Care (3:10-4:10PM)	☐ Monthly	☐ Drop-In
☐ After School Care (3:10-6:00PM)	☐ Monthly	☐ Drop-In

Parent Signature _____Date _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick Up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

Any Changes/Additional Information _____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number

2020-2021 Student Accident Coverage

Serviced by: **K&K Insurance Group, Inc.** Phone: 855-742-3135

***Remember to visit our website for faster enrollment:* www.studentinsurance-kk.com**
Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.

ACCIDENT ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

SCHEDULE OF BENEFITS: *Maximum Benefits Paid As Specified Below. Medically Necessary and Reasonable Charges are based on the 75th percentile.*

Compare and Choose	**Low Option Accident Only**	**High Option Accident Only**
Maximum Benefit:	$25,000 (For Each Injury)	$25,000 (For Each Injury)
Deductible:	$0	$0
Inpatient		
Room & Board:	Up to $150 per day/ Semi-private room rate	80% of Reasonable Charges/ Semi-private room rate
Hospital Miscellaneous:	$600 maximum per day	$1,200 maximum per day
Registered Nurse:	75% of Reasonable Charges	100% of Reasonable Charges
Physician's Visits: *(Benefits are limited to one visit per day and do not apply when related to surgery)*	$40 first day/$25 each subsequent day	$60 first day/$40 each subsequent day
Outpatient		
Day Surgery Miscellaneous:	$1,000 maximum	$1,200 maximum
Physician's Visits: *Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)*	$40 first day/ $25 each subsequent day	$60 first day/ $40 each subsequent day
Outpatient Physical Therapy: *(Benefits are limited to one visit per day)*	$30 first day/$20 each subsequent day/ 5 days maximum	$60 first day/$40 each subsequent day/ 5 days maximum
Emergency Room Services: *(Treatment must be rendered within 72 hours from the time of the injury)*	$150 maximum	$300 maximum
X-Rays:	$200 maximum	$600 maximum
Diagnostic Imaging Services:	$300 maximum	$600 maximum
Laboratory:	$50 maximum	$300 maximum
Prescription Drugs:	$75 maximum	$200 maximum
Injections:	No Benefits	No Benefits
Orthopedic Braces & Appliances:	$75 maximum	$140 maximum
Inpatient and/or Outpatient		
Surgery Fees:	$1,000 maximum	$1,200 maximum
Anesthetist:	20% of Surgery Allowance	25% of Surgery Allowance
Assistant Surgeon:	20% of Surgery Allowance	25% of Surgery Allowance
Ambulance:	$300 maximum	$800 maximum
Consultant:	$200 maximum	$400 maximum
Dental Treatment due to Injury to Teeth: *(For Injury to sound, natural teeth only)*	$10,000 maximum per policy term	$10,000 maximum per policy term
Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a Covered Injury:	100% of Reasonable Charges	100% of Reasonable Charges
Durable Medical Equipment:	No Benefits	No Benefits
Maternity:	No Benefits	No Benefits
Complication of Pregnancy:	No Benefits	No Benefits

Expenses for the following are not covered: Prosthetic Devices, Mental and Nervous Disorders, Injections.

Details of these benefits may be found in the Master Policy on file at the School District. ***NOTE:*** *This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control the payment of benefits.*

Choose Your Coverage Plan: *One-Time Payment For Accident Coverage*

PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW

Coverage Effective Date: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.

Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

	Low Option	High Option
24-Hour Accident (Students & Employees) Around-the-clock/anywhere in the world. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football.	$82.00	$122.00
24-Hour Accident (Summer Only Coverage, Students Only) Summer begins on the first day after the school year ends. Summer ends the first day of the next school year.	$27.00	$38.00
At-School Accident (Students & Employees) During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes. School Sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.	$26.00	$35.00
High School Football (Full Year) Play or practice of regularly scheduled football. Consult your Athletic Department for enrollment instructions.	$134.00	$205.00
High School Football (Spring Only Rates) For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.	$59.00	$87.00
High School Football and At-School Accident (Covers all athletics)	$160.00	$240.00
High School Football and 24-Hour Accident (Covers all athletics)	$216.00	$327.00

Facts about the Policy

1. WHO IS ELIGIBLE: students of the policyholder who make the required premium contribution for the coverage selected are eligible. Student status continues after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy on file with the school district is a non-renewable policy.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year.
   All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.
6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year
7. CANCELLATION: Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
8. STUDENT TRANSFER: The policy continues to be in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.

1799(MD_MB_ENG_03/20)

Enroll online at:

www.StudentInsurance-kk.com

or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to Nationwide Life Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Mail completed enrollment form with payment back to:
   K&K Insurance Group,
   P.O. Box 2338
   Fort Wayne, IN 46801-2338
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

Administered by:

K&K Insurance Group, P.O. Box 2338,
Fort Wayne, IN 46801-2338

Cut out card and retain for your records

STUDENT INSURANCE CARD

Student's Name_____

If premium has been paid, the student whose name appears above has been insured under a Policy issued to:

School District:_____

Accident Only Coverage: ❑ 24-HOUR ❑ 24-HOUR (Summer Only Coverage)
❑ AT-SCHOOL ❑ FOOTBALL ❑ FOOTBALL (Spring Only)

Paid by Check #_____ Amount Paid:_____ Date Paid:_____

Policy #_____

Underwritten by: Nationwide Life Insurance Company
Claims Questions: K&K Insurance Group, Inc.
1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917

Policy Exclusions and Limitations for Accident Only Coverages

The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced. ***We will not pay Benefits for:***

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders: *We will not pay Benefits for:*

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
5. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
6. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
7. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
8. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
9. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
10. Expenses Incurred for supervision of an anesthetist.
11. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
12. Expenses Incurred for subsequent repairs and replacement of prosthetic devices.
13. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law or similar law.

Accident Only Definitions:

Injury A bodily injury which is:
1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:
1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered as one Injury.

Accidental Death & Specific Loss Benefits:

The Aggregate Limit is $500,000 and is the maximum amount payable for claims incurred for all Insureds under the Policy which are caused by any one Incident that occurs when the Policy is in force. If this limit is not sufficient to pay the total of all such Claims, then the Benefit payable to any one Insured will be determined in proportion to our total aggregate limit of liability. This Aggregate Limit of Liability applies only to Accidental Death and Specific Loss Benefits.

Life	$10,000
Both arms or both legs	$10,000
Both hands and both feet	$10,000
One arm and one leg	$10,000
One hand and one foot	$10,000
Either both hands or both feet	$10,000
Speech and hearing in both ears	$10,000
The sight of both eyes	$10,000
The sight of one eye and either one hand or one foot	$10,000
Either one arm or one leg	$7,500
Either one hand or one foot	$5,000
Speech or hearing in both ears	$5,000
Sight of one eye	$5,000
Hearing in one ear	$2,500
Both the thumb and index finger of one hand	$2,500

Enroll online for quicker service at www.StudentInsurance-kk.com

or complete and mail this form

Enrollment Form (School Year 2020-2021)

Student's Last Name:_____

Student's First Name:_____

Student's Middle Name:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Name of School District (required):_____

Name of School:_____

Grade Level: ❑ Pre-K/Headstart ❑ Kindergarten/Elementary ❑ Middle School ❑ High School/Above

Signature of Parent or Guardian:_____

Date:_____ Email Address:_____ Phone Number:_____

Student Insurance Plan Options — *Check Your Selection:*

Accident Only Coverage Plans	Low Option	High Option
24-HOUR	❑ $82.00	❑ $122.00
24-HOUR Summer Only	❑ $27.00	❑ $38.00
AT-SCHOOL	❑ $26.00	❑ $35.00
HIGH SCHOOL FOOTBALL COVERAGE Full Year	❑ $134.00	❑ $205.00
HIGH SCHOOL FOOTBALL COVERAGE Spring Only *For New Players*	❑ $59.00	❑ $87.00
HIGH SCHOOL FOOTBALL and AT-SCHOOL *Covers all athletics*	❑ $160.00	❑ $240.00
HIGH SCHOOL FOOTBALL and 24-HOUR *Covers all athletics*	❑ $216.00	❑ $327.00

Enclose check for total payment payable to: Nationwide Life Insurance Company. Checks, money orders, or credit cards accepted.
DO NOT SEND CASH
TOTAL ENCLOSED: $_____

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Mail this completed form with payment back to: *K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338*

Complete this section only if you wish to pay with a Credit Card

Full name as it appears on card
First Name:_____ MI:_____ Last Name:_____
Billing Address *(if different than above)*
Street #_____ Address_____ Apt #_____

City:_____ State:_____ Zip:_____
Card Number: | | | | | | | | | | | | | | | | Expiration Date: Month: | | Year: | | | |

Cardholder signature:_____

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)