



SHORT-TERM (24-HOUR) COVERAGE
Accident Insurance Enrollment Form 2009-2010 School Year
100% Participation Required

Provides excess accident and emergency sickness medical coverage and accidental death and dismemberment coverage for all of your students participating in school sponsored and supervised activities involving overnight travel and/or periods without direct and immediate school supervision. **Rate is \$1.60/person/calendar day.** Coverage consists of **BASIC** and **CATASTROPHIC** injury benefits.

BASIC accident medical benefits are paid on an excess basis at 100% of Usual, Reasonable & Customary charges up to \$25,000/injury and up to \$500 for Emergency Sickness ("Emergency Care Benefit" in IA, IN, KS, and MO). Includes benefit for pre-approved Medical Evacuation expenses up to \$25,000 and up to \$10,000 of expenses for Repatriation of Remains to home country. Covered charges for injuries are limited to those incurred within one year from date of first treatment and Emergency Sickness benefits are limited to those charges incurred within 24 hours from the onset of sickness. **The policy has complete details of provisions, limits and exclusions.** Underwritten by BCS Insurance Company in AZ, CA, IA, IN, KS, MO and NV.

CATASTROPHIC benefits are subject to a deductible of \$25,000 and are then paid at 100% of Reasonable and Customary Charges up to \$1,000,000. Includes additional cash benefits of up to \$500,000 (depending upon the severity of the loss) and accidental death benefit of \$25,000. Underwritten by ACE American Insurance Company.

APPLICATION AND LIST OF NAMES

MUST BE RECEIVED BY MYERS-STEVENS PRIOR TO THE START DATE OF ACTIVITIES, OTHERWISE COVERAGE WILL BEGIN UPON RECEIPT. PREMIUM IS DUE WITHIN 10 DAYS OF THE START OF THE ACTIVITY.

Please complete the entire form, attach list of names, and return with your premium or billing information to:

Myers-Stevens & Toohey & Co., Inc., 26101 Marguerite Parkway, Mission Viejo, CA 92692-3203
 (949) 348-0656 or (800) 827-4695, fax number (949) 348-0963

*It is required that all students attending this event are covered, whether they have other insurance or not.
 This plan does not cover paid school employees. (Coverage is optional for Parent chaperones, include names with list of students)*

BILL TO: NEW REVISED

DISTRICT: _____

SCHOOL: _____ PHONE #: () _____

ADDRESS: _____

DATE(S): From: _____ To: _____

DESTINATION/ACTIVITY: _____

Coverage Requested By: _____

Print Name Signature:

PLEASE NOTE: THERE IS A MINIMUM PREMIUM REQUIREMENT.
Premium is due within 10 days of the start date of activity

Calculate Premium Due: _____ x _____ x \$1.60 = _____
 # of Participants # of Calendar Days Premium Rate **PREMIUM DUE (\$35 minimum)**

Please include list of participants with application.

METHOD OF PAYMENT: REQUEST INVOICE NO INVOICE NEEDED P.O. NUMBER _____

MC/VISA AUTHORIZATION: MC: _____ VISA: _____ - _____ - _____ - _____

_____/_____
 Month / Year Security Code Zip Code of Cardholder

 Name of Cardholder Cardholder's Signature