CHILD CARE

GO FROM "BOO-BOOS" TO "ALL BETTER"

GROUPROTECTORSM
Group Accident Medical Insurance

QUOTE & BIND ONLINE
Scan this code or go to
www.nationwide.com/grouprotector

Nationwide®
On Your Side

ACCIDENTS HAPPEN.
But that doesn't have to keep you off the playground.

Let Nationwide® help. Our **GROU**PROTECTOR℠ accident medical insurance provides peace of mind that keeps the focus on fun. Our policy provides medical expense benefits as well as death and specific loss benefits to all program participants. You can even choose to cover program staff in addition to participants.

Pick the coverage level that's right for your group

GrouProtector offers both primary and excess medical plans. Which one's right for your group?

Primary medical plan

- Ideal for groups with participants generally not covered by other insurance
- Typically the first plan to pay claims after a covered event
- Pays covered expenses regardless of other insurance coverage
- Payments from other insurance coverage may be reduced as needed

Excess medical plan

- Ideal for groups with participants generally covered by other insurance
- Typically the last plan to pay claims after a covered event
- Will not pay covered expenses to the extent paid by other insurance coverage
- Essentially pays for other plans' deductibles and coinsurance
- Also pays remaining expenses after benefits exhausted from other plans

Who in your group is covered?

You have two choices of who can be covered:

- Participants only
- Participants and staff

Whichever option you choose, 100% of those individuals are insured.

What activities are covered?

- All program sponsored and supervised activities are covered
- Direct travel to and from these activities is also covered

Coverage excludes interscholastic sports for grades 7-12.

SHR-0126AO (05/13)

NON-RESIDENT CHILD CARE Accident Insurance Policy Application

Print or type only

which, upon acceptance and approval by **Nationwide Life Insurance Company**—Columbus, Ohio 43216, will become a part of Specified Hazard Insurance Policy Number 502- Office Use Only

1. Name of Plan Sponsor Group's Name

Address Street City State Zip County

2. Policy Term: The policy term starts at **12:01 a.m.** on ___/___/___ which is the effective date, and ends at **12:01 a.m.** on ___/___/___ which is the: ☐ termination date (short-term—up to 3-month policy term) or ☐ first renewal date (year-round coverage—12-month policy term).

3. Covered Activities

Supervised activities (excluding interscholastic sports for grades 7 through 12) sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities. (550)

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

Benefit Provisions	Maximum Benefit Amounts			
	CLASS 1	CLASS 2	CLASS 3	CLASS 4
Accidental Death & Specific Loss with a $250,000 overall maximum for any one accident.				
Death	$5,000	$5,000	$7,500	$5,000
Specific Loss (Face Amount)	15,000	15,000	15,000	15,000
MEDICAL EXPENSE				
Accident Deductible	None	None	None	None
Overall Maximum	25,000	25,000	25,000	25,000
OFFICE USE ONLY	2220P 4220E	2220P 4220E	2220P 4220E	2220P 4220E

5. Premium Rates by Class(es) of Eligible Persons – check class(es) and Medical Expense Plan desired

Class	Eligible Persons	Premium Rates per Eligible Person: ☐ Medical Expense PRIMARY Plan	☐ Medical Expense EXCESS Plan
	All participants or all participants and staff of the plan sponsor's non-resident:		
1	☐ Child care program (including a day care center, home day care, nursery, before/after school care and Latch Key), kindergarten, Operation Head Start, pre-school and short-term study school—up to 3 months coverage (PHI550)	$ 2.00	$ 1.45
2	☐ Child care program (including a day care center, home day care, nursery, before/after school care and Latch Key), kindergarten, Operation Head Start and pre-school—12 month policy term		
	Summer only program (C38)	2.00	1.45
	9 month half-day program (PHI551-C39)	3.20	2.40
	9 month full-day program (PHI552-C40)	5.75	4.10
	12 month half-day program (PHI553-C41)	4.25	3.10
	12 month full-day program (PHI554-C42)	7.50	5.50
3	☐ Montessori, Religious and Waldorf day school programs (grades 1 and up)—12 month policy term (PHI556-C36/37 or 44)	10.75	8.25
4	☐ Disabled child development program—12 month policy term (PHI558-C73)	9.00	6.50

The minimum premium per policy term is $225 if the medical expense PRIMARY plan has been elected and $175 if the medical expense EXCESS plan has been elected.

6. The Policy is to cover all eligible persons which include: ☐ participants only (06), or ☐ participants and staff (09).

7. It is understood and agreed that: (a) the premium will be paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance; and (b) **premium will be paid as follows: for up to a 3-month term-in advance; or, for a 12-month policy term-annually in advance based on the total number of eligible persons anticipated to be insured during the policy term** (BF50).

(NY) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

By sending your check to Nationwide Life Insurance Company ("Nationwide"), you give your consent to Nationwide to authorize our financial institution to convert your check into an electronic fund transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment and you will not receive a canceled check. For authorized checking account withdrawal (also called Automated Clearing House or "ACH") call 800.525.8669.

By signing below, you agree that you have read all of the Fraud Warnings provided with this application.

Previous Policy Number

Date

Appointed Agent's Signature and Number

Appointed Agent's Phone Number

Appointed Agent's E-mail Address

Signature of Applicant

Printed Name and Title of Applicant

Address of Applicant

Applicant's Phone Number

Applicant's E-mail Address

☐ Check box if no agent was used.

GR-9050
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(Office Use)

SHR-0126AO (05/13)

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 overall maximum benefit amount, all covered expenses incurred within 3 years from such date.

Covered expenses means the reasonable and customary charges for local ("local" not applicable in a CT contract) 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 (natural teeth in SC);

(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 excess medical has been elected, we will not pay benefits for, nor can this plan's deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under certain other policies and/or health plans as stated in the policy.

Coverage is provided under policy form No. GR-9051-2 if the coverage is full-term – 12 months, or GR-9051-4 if the policy is short-term.

Certain provisions of the policy are summarized in this brochure. All benefits are subject to the policy, which alone constitutes the agreement under which payments are made.)

Death Benefit

If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay the death benefit less any specific loss benefit paid because of the same accident. The one year limit does not apply in a PA or WV contract.

Specific Loss Benefit

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:

Specific Loss	% of 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 Same Hand	25%

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. 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.

Policy Exclusions and Limitations

We will not pay benefits for expenses incurred for:

(1) the examination, prescription, purchase or fitting of eyeglasses, contact lenses or hearing aids; or

(2) treatment by a person employed or retained by the plan sponsor or its 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 (if a NJ contract, care or treatment furnished by a member of the insured's immediate family).

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

(4) intentional self-destruction or an attempt at it or intentional self-inflicted injury (if MO 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.

PREMIUM REPORT (Must be completed for Application to be accepted)

Program(s): ☐ up to 3 mos., ☐ up to 9 mos., and/or ☐ up to 12 mos.

Program(s) include(s) non-resident: ☐ Before/After School Care, ☐ Day Care, ☐ Disabled Child Development, ☐ Home Day Care, ☐ Kindergarten, ☐ Latch Key, ☐ Montessori Day School, ☐ Nursery, ☐ Operation Head Start, ☐ Pre-School, ☐ Religious Day School, ☐ Study School, ☐ Waldorf Day School, ☐ Other_____

Number of eligible persons anticipated to be insured				
Participant	Staff	Total	Premium rate per eligible person	Premium Due
+	=	x $	= $	
+	=	x $	= $	
+	=	x $	= $	
+	=	x $	= $	
+	=	x $	= $	
		Total Premium Due (Subject to policy minimum*)		$

*The annual minimum premium per policy term is $225 for PRIMARY medical coverage and $175 for EXCESS medical coverage.

I certify that to the best of my knowledge and belief: (1) the preceding information is correct and complete; (2) premium is being paid for the total number of eligible persons who are anticipated to be insured during the policy term; and (3) **the premium is being paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance.**

Date _____ by Signature of Applicant _____

Day Telephone Number _____ Fax Number _____

E-mail Address _____

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") or credit card payment call 800-525-8669.

How do you apply and pay for coverage?

Complete ALL fields on the application. Be sure to sign and date where indicated. **We need to receive the completed application and premium payment BEFORE the desired policy effective date.**

APPLICATION OPTIONS

Online at www.nationwide.com/grouprotector.

Mail the application and Premium Report, if applicable, to Nationwide Specialty Insurance, PO Box 1970, Springfield MA 01101. Enclose payment or submit payment with a credit or debit card (see below).

Fax the application and Premium Report, if applicable, to 1-413-214-7761. Submit payment by credit or debit card, ACH or if you prefer you may mail a check (see below).

E-mail: Scan the application and Premium Report, if applicable, and email them to grouprotector@consolidatedhealthplan.com. Include payment by filling out, scanning and emailing the ACH form or submit payment with a credit or debit card. If you prefer you may mail a check (see below).

PAYMENT OPTIONS

Pay by mail: Mail payment to Nationwide Specialty Insurance, PO Box 1970, Springfield MA 01101

Pay by credit or debit card: Call 1-800-525-8669

Pay by electronic check (ACH): Download and complete the Automated Clearing House (ACH) Authorization Form found at www.nationwide.com/ach and mail, fax or e-mail the ACH form with your application.

How do you contact us?

1-800-525-8669
(8:00 a.m. – 5:00 p.m. ET, M-F)

1-413-214-7761

Nationwide Specialty Insurance,
P.O. Box 1970, Springfield, MA 01101

grouprotector@
consolidatedhealthplan.com

nationwide.com/grouprotector

Underwritten by Nationwide Life Insurance Company.

Administered by Consolidated Health Plans

Nationwide® *On Your Side*

Fraud Warnings

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

(FL) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(KY) Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

(LA) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(MD) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(MO) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(PA) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

(PR) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(WA) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim 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 and subjects such person to criminal and/or civil penalties.

Please read these important notices and warnings

All cases are subject to the acceptance of the risk and may be subject to review of prior claims experience.

Unless otherwise specified in the Benefit Provisions, this policy does not provide coverage for sickness or for legal liability.

This policy does not provide basic hospital, basic medical or major medical insurance. (In NY: as defined by the New York State Insurance Department)

(NY) The insurance offered in this brochure is (1) not a deposit; (2) not insured by the Federal Deposit Insurance Corporation; and (3) not guaranteed by the bank, trust company, savings bank, savings and loan associations, federal savings association or national bank.