Virginia High School League
Voluntary Catastrophic Accident Insurance Form
2016-2017

GENERAL INFORMATION

Participating School ____
Full Legal Name

Address ____
Street City State Zip

Participating School is a member of the ______________________________(sanctioning body).

COVERAGE DESIRED (Please indicate via checkmark the class(es) to be covered)

[ ] **Class I:** All middle school interscholastic student athletes, student managers, student trainers, student cheerleaders, or students participating in interscholastic competition that is governed by the regulations of the state high school athletic/activities authority, including school-supervised practice, tryouts, game-related activities and covered travel as defined in the policy.

[ ] **Class II:** All middle school and high school students participating in intramural and club sports; physical education classes; classroom and laboratory activities for credit; off-campus group activities assigned for credit; faculty-sponsored clubs, plays and concerts; off-campus faculty-sponsored and supervised field days; overnight domestic field trips seven days or less in duration and covered travel as defined in the policy.

BENEFIT SELECTION AND PREMIUM CALCULATION (Please select only one plan)

[ ] **$1,000,000 Maximum (Minimum Premium = $600.00)**

Number of Class I Insured Persons _________ x **$2.55**= $_______
Number of Class II Insured Persons _________ x **$2.05** = $_______

[ ] **$2,000,000 Maximum (Minimum Premium = $650.00)**

Number of Class I Insured Persons _________ x **$3.40** = $_______
Number of Class II Insured Persons _________ x **$2.75**= $_______

[ ] **$3,000,000 Maximum (Minimum Premium = $750.00)**

Number of Class I Insured Persons _________ x **$3.65 =** $_______
Number of Class II Insured Persons _________ x **$3.20=** $_______

TOTAL PREMIUM $_______________
(Premium shown above is fully earned and nonrefundable)

ON REVERSE SIDE LIST SCHOOLS TO BE COVERED AND SIGN.

NAMES OF SCHOOLS AND GRADES TO BE COVERED	# OF STUDENTS

PREMIUM PAYMENT

Make your check payable to Mutual of Omaha and mail it with this form and the completed application to:

Mass Benefits Consultants, Inc.
P.O. Box 828
Annandale, VA 22003-0828

It is understood that the effective date of coverage under this program will be__________________, or if later, the date this form and the premium are received by the Company.

Coverage underwritten by Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

All above information requested is required for policy issuance. The licensed agent is required to complete the section below. Policies can not be issued without all the required information being completed.

Local/Regional Licensed Agency

Agency Name: ________________________________ License Number: ________________________________

Agent Name (Printed): ________________________________ Agent Address: ________________________________

City, State, Zip: ________________________________ Phone Number: ________________________________

Signature: ________________________________ Date: ________________________________
(Licensed Agent)
Email Address: ________________________________

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175

Home Office Use Only

Policy Number(s):__________________________

Participant Accident Insurance Application

Applicant (Full Legal Name)____

Address____

City____________________________ State__________ Zip______________

Requested Effective Date ____

If this application is approved, insurance will become effective on the requested effective date, unless Mutual of Omaha Insurance Company sends written notice of a different effective date.

ACKNOWLEDGMENT AND SIGNATURE

All statements in this application and any claims experience data provided to Mutual of Omaha Insurance Company are true and complete and will be relied upon by Mutual of Omaha Insurance Company to determine whether to issue a policy. Such statements and claims experience data, along with the group insurance proposal from Mutual of Omaha Insurance Company, are the basis for any policy issued by Mutual of Omaha Insurance Company. Any incomplete, incorrect or misleading statements or data may void this application and any issued policy as of the effective date.

If an authorized representative at Mutual of Omaha Insurance Company's Home Office does not approve this application, no insurance is in effect at any time and any premium payment received will be returned.

This application is submitted with a premium payment of $_________________________

Signature of Applicant's Authorized Representative______________________________

Typed or Printed Name of Authorized Representative______________________________

Title____________________________________ **Date**____________________

Name of broker, agent and/or insurance agency______________________________

Fraud Warning: 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, may be guilty of a crime and may subject such person to criminal and civil penalties.

Arkansas; District of Columbia; Louisiana; New Mexico; West Virginia Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California Fraud Warning: 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.

Delaware; Florida; Oklahoma Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas Fraud Warning: 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, may be guilty of a crime and may subject such person to criminal and civil penalties as determined by a court of law.

Maine; Tennessee; Virginia Fraud Warning: 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.

Oregon; Rhode Island; Fraud Warning: 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.

Ohio Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.