Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

WELLFLEET INSURANCE COMPANY
To get information or file a complaint with your insurance company or HMO:

Call: Wellfleet Group, LLC at
Toll-free: 877-657-5030
Online:
https://wellfleetstudent.com/contact/
Email: appeals@wellfleetinsurance.com
Mail: P.O. Box 15369
Springfield, MA 01115-5369

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

WELLFLEET INSURANCE COMPANY
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Wellfleet Group, LLC at al
Teléfono gratuito: 877-657-5030
En línea: https://wellfleetstudent.com/contact/
Correo electrónico: appeals@wellfleetinsurance.com
Dirección postal: P.O. Box 15369
Springfield, MA 01115-5369

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Wellfleet Insurance Company's toll-free telephone number for information or to make a complaint at:

1-877-657-5030

You may also write to Wellfleet Insurance Company at:

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact Wellfleet Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Wellfleet Insurance Company's para obtener información o para presentar una queja al:

1-877-657-5030

Usted también puede escribir a Wellfleet Insurance Company:

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación,, usted debe comunicarse con Wellfleet Insurance Company primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

MP0000826022

WELLFLEET INSURANCE COMPANY
TRUST ADOPTION AGREEMENT ENROLLMENT FORM
2023-2024 School-Year Plans | PreK- 12 Schools

Name of school LAKEHILL PREPARATORY SCHOOL
School Mailing Address 2720 HILLSIDE DR City DALLAS
State TX Zip 75214 E-Mail bmccoskey@lakehillprep.org
Telephone (214) 826-2931 Ext. 114 Fax: (214) 827-0828

Please complete the following:
Opening date of pre-season practice* 08/01/2023
Opening date of school year* 08/01/2023
Closing date of school year 07/31/2024

Total Anticipated Enrollment and Plans for 2023-2024											
All Plans MUST MATCH (all enrolled students must be covered)	**Estimated Number of Students**	**Cost Per Participant**			**Premium**		**Estimated Number of Students**	**Cost Per Participant**			**Premium**
PREK (PK STUDENTS STARTING AT AGE 3)	**80%**					**OR**	**100%**				
Plan P ($0 deductible)		x	$5.75	=				x	$7.20	=	
Plan P 100 ($100 deductible)		x	$4.55	=				x	$5.75	=	
DAY STUDENTS (K And UP)	**80%**					**OR**	**100%**				
Plan D ($0 deductible)		x	$21.80	=				x	$27.25	=	
Plan D100 ($100 deductible)		x	$16.60	=			425	x	$20.65	=	8,776.25
BOARDING STUDENTS	80%					**OR**	100%				
Plan B ($0 deductible)		x	$114.20	=				x	$146.35	=	
Plan B100 ($100 deductible)		x	$83.25	=				x	$112.25	=	
OPTIONAL COVERAGE	80%					**OR**	100%				
Catastrophic Supplement** Plan C		x	$2.85	=			425	x	$3.55	=	1,508.75
Total estimated premium	=									=	10,285.00

Minimum premium is $250

Send this form – along with a check for $250, payable to Wellfleet Insurance Company, as a deposit credited toward the total premium to be billed in September to:

Wellfleet Insurance Company
c/o Wellfleet Group, LLC, PO Box 15369, Springfield, MA 01115-5369

The undersigned hereby requests participation in the Independent School Student Accident Insurance Trust, which is established for the purpose of holding and administering the Group Policy under which participating schools secure student accident insurance. The undersigned agrees, if accepted for participation, to abide by the provisions of the Trust and the insurance plans selected by the Trustees, and to cooperate fully with the Trustees and the Professional Manager selected by the Trustees. The undersigned acknowledges that the Trustees have made no representations to him/her, that any representations to him/her were made by the Professional Manager (Independent School Management, Inc.), and thereby agrees to look only to the Professional Manager in the event of any dispute from such representation. 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 may be a crime.

Approved for the school by: Bruce McCoskey
Name (*print*): BRUCE MCCOSKEY
Title: CFO Date: 07/11/2023

***IMPORTANT NOTICE**
- In no event can coverage be effective prior to the August 1, 2023 plan effective date.
- Coverage cannot be effective prior to the receipt of this signed Trust Adoption Agreement and $250 deposit.
- This Plan is not available in all states.

Wellfleet Insurance Company
5814 Reed Road Fort Wayne IN 46835

Underwritten by: Wellfleet Insurance Company
5814 Reed Road
Fort Wayne IN 46835

Administrator: Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
(877) 657-5039

Wellfleet Insurance Company is referred to in this Policy as “We”, “Us”, “Our” or “the Company.” We have issued this Policy to the Policyholder named in the attached application. The Policy insures those students who are enrolled in a Participating School.

INSURING AGREEMENTS

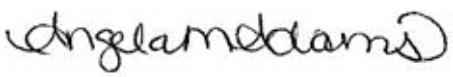
COVERAGE: We will pay the benefits provided in the Policy for any Insured who is regularly enrolled in the Participating School. Benefits are provided to cover the expenses incurred due to an Accidental Injury sustained while the Policy is in force. We will pay the benefits under the terms of the Policy in consideration of the application for this Policy and the payment of all premiums paid.

This Policy is effective on the date shown in the attached application. It is issued for an initial term of one year. The Policy may be continued in force thereafter as herein provided. All days are full calendar days, Standard Time, at the Policyholder's address. All time periods begin and end at 12:01 A.M., local time at the Policyholder's address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is governed by the laws of the state in which it is delivered.

Signed for the Company by its Secretary and President.



President Andrew M. DiGiorgio

Secretary Angela Adams

BLANKET STUDENT ACCIDENT INSURANCE

THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.

THIS POLICY CONTAINS A NON-DUPLICATION OF BENEFITS PROVISION:
Benefits under this Policy may be limited to expenses that are in excess of benefits payable under other insurance.

Wellfleet Insurance Company
5814 Reed Rd, Fort Wayne IN 46835

SCHEDULE OF BENEFITS AND RATES

Coverage is provided each Insured Student under the Plan or Plans shown below as selected by the Participating School.

PLAN	BENEFIT PERCENTAGE	MEDICAL MAXIMUM PER BENEFIT PERIOD	BENEFIT PERIOD FROM DATE OF INJURY**	DEDUCTIBLE
**Plan D	100%	$ 30,000.00	One Year	$ 0.00
**Plan D100	100%	$ 30,000.00	One Year	$ 100.00
**Plan P	100%	$ 30,000.00	One Year	$ 0.00
**Plan P100	100%	$ 30,000.00	One Year	$ 100.00
**Plan B	100%	$ 30,000.00	One Year	$ 0.00
**Plan B100	100%	$ 30,000.00	One Year	$ 100.00
*Plan C	100%	$1,000,000.00	Two Years	$ 30,000.00

* Benefits under Plan C are subject to meeting the applicable Deductible within one year from the date of injury.

** Under these plans, the Benefit Period for Dental Treatment is 104 weeks.

SCHEDULE OF PREMIUM RATES

Annual Premium per Insured Student

DAY SCHOOLS

Plan D	$ 27.25
Plan D100	$ 20.65
Plan P	$ 7.20
Plan P100	$ 5.75

BOARDING SCHOOLS

Plan B	$ 146.35
Plan B100	$ 112.25

CATASTROPHE COVERAGE

Plan C	$ 3.55

The premium for the Policy is the amount attributable to the School based on the rate for each student in grades pre-kindergarten through 12 regularly enrolled in the School.

PREMIUM DUE DATE: The premium is due within 31 days of the effective date of the Policy. Premiums are payable to the Company at its Office in Fort Wayne, Indiana or to any representative of the Company authorized to accept such premiums.

TABLE OF CONTENTS

PLANS OF INSURANCE

A. MANDATORY PLANS

Each Insured will be covered, subject to the Exclusions, Limitations and other Policy provisions, under one of the following mandatory plans.

PLAN D, PLAN D100, PLAN P and PLAN P100

This plan pays benefits for an Accidental Injury that occurs:

1. While on the School premises. This means the times: (a) during the hours and days when classes are in session; and (b) and while the Insured is participating in or attending a School-Sponsored, Directly Supervised Activity. This includes athletics.
2. While away from the School premises, if the Insured is participating in a School-Sponsored, Directly Supervised Activity. This includes all athletics and field trips (even overseas).
3. While commuting directly and without interruption to or from the Insured's residence and the Participating School for regular school-day sessions.
4. While traveling to or from a School-Sponsored, Directly Supervised Activity in a Participating School-authorized vehicle. This includes athletic events.
5. Coverage is extended to all visiting/interviewing students, who visit at the request or invitation of the Participating School. This includes students who visit the school for sports team try-outs, on either a day or boarding basis, depending on the Plan the School has in place for their regularly attending students. Coverage will be provided only: (a) while on the school premises; and (b) while participating in or attending any School-Sponsored, Directly Supervised Activity consistent with the purpose of the visit. It does not cover students or groups who are on an opposing team of another school or who are visiting for the purpose of competing or participating in a School Sponsored, Directly Supervised Activity, game, or event as a competitor of the Participating School.

PLAN B and PLAN B100

This plan provides benefits for an Accidental Injury that occurs as the result of all activities listed for PLAN D and PLAN D100. It expands that plan to include 24-hour coverage while the Insured is under the care and direction of the Participating School. Coverage also extends to: (a) vacation periods, if the Insured is residing on the campus of the Participating School during such times; and (b) weekend leaves, if the Insured does not go to his or her principal place of residence.

PLAN C

This plan provides benefits for an Accidental Injury that occurs as the result of all activities listed in PLAN D, PLAN D100, PLAN P, PLAN P100, PLAN B or PLAN B100, as applicable to the Insured. It includes coverage for practice or competition in any interscholastic athletics. This includes travel directly to or from such practice or competition in a Participating School-authorized vehicle.

B. 24-HOUR VOLUNTARY EXTENSION PLAN

Under this voluntary plan, coverage, to the extent provided under PLAN D, PLAN D100, PLAN P, PLAN P100, PLAN B or PLAN B100, as applicable to the Insured, is extended to 24 hours a day to cover an Accidental Injury that occurs when the Insured is not under the care and direction of the Participating School. This coverage is subject to all the terms, exclusions and limitations set forth in this Policy and attachments, if any, which are not inconsistent herewith. This coverage is provided for enrolled Insureds for whom the applicable premium is paid.

DEFINITIONS

The following terms are used throughout the Policy. They are used to describe Our rights and those of the Policyholder and Participating Schools. Please refer to these terms when reading the Policy.

Accidental Injury means an accidental bodily injury which occurs while the Insured is covered under this Policy. It must be the result of an unexpected, external, violent and sudden event that is independent of any other cause.

Benefit Period means the period of time which starts on the date of the Accidental Injury. It continues for the period of time shown on the Schedule of Benefits and Rates. Benefits are payable only for expenses incurred during the Benefit Period for each Accidental Injury. Each separate Accident is subject to a new Benefit Period.

Deductible Amount means the greater of:

1. the amount shown in the Schedule of Benefits and Rates; or
2. the amount collectible from any other insurance sources, subject to the Non-Duplication of Benefits Provision.

Hospital means a short term, acute care, general hospital that:

1. operates as a Hospital pursuant to law;
2. is primarily engaged in providing diagnostic services and therapeutic services for diagnosis, care and treatment of sick or injured persons as inpatients by or under the continuous supervision of Physicians;
3. provides 24-hour nursing service by or under the supervision of Registered Nurses on duty or on call;
4. provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

A Hospital does not include, other than incidentally, the following:

1. convalescent homes or convalescent, rest or nursing facilities;
2. facilities primarily affording custodial, educational or rehabilitative care; or
3. facilities for the aged, drug addicts or alcoholics; or
4. a place primarily for the treatment of tuberculosis.

Immediate Family Member means the Insured, the spouse of the Insured or the children, parents, brothers or sisters of the Insured or the Insured's spouse.

Insured means any student who is regularly enrolled in a Participating School.

Medical Maximum means the maximum amount We will pay for all expenses incurred for any one Accident per Benefit Period.

Participating School means an independent school which has agreed to participate in the Trust, which is the Policyholder.

Physical Therapy means any form of physical therapy, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

Physician means a practitioner of the healing arts operating within the scope of his or her license. A Physician may not be an Immediate Family Member.

School-Sponsored, Directly Supervised Activity means:

1. any activity which the Participating School authorities require the Insured to attend; or
2. any activity of the Insured's school which is under the sole control and supervision of school authorities.

This includes activities which are under the sponsorship of the Participating School, but does not include activities with any non-school group.

Usual and Customary means the normal charge of the provider in the absence of insurance for a service or supply, but not more than the prevailing charge in the area for a:

1. like service by a provider with similar training or experience; or
2. supply that is identical or substantially equivalent.

BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICE

We pay a benefit if the Insured incurs expenses due to a covered Accidental Injury. The expenses must be incurred for: (1) necessary medical or dental treatment by a Physician or surgeon; or (2) confinement in a Hospital. The amount We pay is equal to the Benefit Percentage of the Usual and Customary expenses incurred.
This is subject to the following:

1. The Insured must first satisfy the Deductible Amount for each Benefit Period. We pay the Usual and Customary charges in excess of the Deductible Amount.
2. Treatment or Hospital confinement must begin within 30 days after the date of the Accidental Injury.
3. Expenses for such care must be incurred within the Benefit Period.
4. We pay up to the Medical Maximum for each Benefit Period.

The Schedule of Benefits and Rates shows the: Benefit Percentage; Deductible Amount; Benefit Period; and Medical Maximum.

BENEFIT FOR ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT

If, as the result of a covered Accidental Injury, an Insured suffers one of the following losses, We will pay the benefit shown for that loss. The loss must occur within 180 days from the date of an injury which results directly and independently of all other causes. In the event of more than one loss as the result of any one covered injury, only one of the listed benefits, the largest, will be payable.

Loss of Life	$5,000.00
Loss of One Hand, One Foot, or Sight of One Eye	$5,000.00
Loss of Both Hands, Both Feet, or Sight of Both Eyes	$10,000.00

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. Payment made under this provision will be in addition to any other benefits payable under this Policy.

NON-DUPLICATION OF BENEFITS PROVISION

Our liability for benefits payable due to expenses incurred will be limited to the part of the expenses, if any, that is in excess of the total benefits payable by other valid and collectible coverage on an expense incurred or provision of service basis. Other valid coverage includes any other insurance or medical service plan; Hospital Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's); Workers' Compensation, federal, state or local government plans (except Medicaid); and automobile no-fault insurance. Incurred expenses include hospital charges, medical surgical and other services resulting from a covered Injury of the Insured. This provision does not apply to the 24-Hour Voluntary Extension Plan. This provision applies only when the premiums for the coverage are paid entirely by the Participating School.

EXCLUSIONS AND LIMITATIONS

This Policy does not provide benefits for:

1. illness or disease in any form;
2. treatment by persons employed or retained by the Policyholder, the Participating School, or by any Immediate Family Member;
3. injuries sustained as a result of operating, riding in or upon, or alighting from a two- or three-wheeled motor vehicle;
4. any intentionally self-inflicted injury, or injuries resulting from being under the influence of any narcotic or alcohol, unless administered on the advice of a physician;
5. injuries resulting from war or any act of war, or active participation in any riot or civil commotion;
6. injuries occurring while violating or attempting to violate any duly enacted law; or
7. expenses incurred after the termination of the Benefit Period.

EXPENSE BENEFIT LIMITATIONS - Dental benefits are limited to treatment of accidental injury to sound, natural teeth.

GENERAL PROVISIONS

INSURED EFFECTIVE DATE: The insurance with respect to an Insured will become effective on the latest of the following dates:

1. The effective date of the Policy;
2. The date the Insured enrolls in the Participating School; or
3. The date the Participating School agrees to participate in the Trust.

INSURED TERMINATION DATE: The insurance of an Insured will terminate on the earliest of the following dates:

1. The date on which the insurance terminates with respect to the Participating School;
2. The date on which the Insured ceases to be enrolled in the Participating School; or
3. The date on which the insurance terminates with respect to the Policyholder.

PARTICIPATING SCHOOL EFFECTIVE DATE: The insurance with respect to a Participating School will become effective on the latest of the following dates:

1. The effective date of the Policy;
2. The date the Participating School agrees to participate in the Trust; or
3. The date the Participating School pays the premium.

PARTICIPATING SCHOOL TERMINATION DATE: The insurance afforded to a Participating School and its insured students will terminate on the earliest to occur of:

1. The date the plan is terminated;
2. The date the Participating School ceases to be a participating member of the Trust; \or
3. The premium due date applicable to a Participating School if the required premium is not paid but subject to a Grace Period of 31 days.

24-HOUR VOLUNTARY EXTENSION EFFECTIVE DATE: The insurance, with respect to the Insured, will become effective immediately upon receipt of premium, by the Company or Our authorized agent, but in no event prior to the opening date of the school year.

24-HOUR VOLUNTARY EXTENSION TERMINATION DATE: The insurance of the Insured will continue uninterruptedly until the date school reopens the following year.

PREMIUM AND GRACE PERIOD: All premiums are payable on or before the date upon which they become due. A grace period of thirty-one days will be allowed for the payment of each premium after the first. The premiums for the insurance afforded under the Policy are stated in the Schedule of Benefits and Rates. They are applied to all benefits in force on the due date including benefits on any Insured then receiving benefits.

The premium rates shown in the Schedule of Benefits and Rates apply to the first year of insurance. We may change benefits and/or rates on any billing date on or after the first Policy anniversary by written notice delivered or mailed to the Policyholder. Such notice must state when the changes will be effective. No changes may occur more than 60 days after date of such notice.

NOTICE OF CLAIM: We must receive written notice of Injury. It must be received within 20 days of the date the claim commences or as soon as reasonably possible. It must be given to Our Policyholder Service Office in Fort Wayne, Indiana. It must contain enough information to identify the Insured.

CLAIM FORMS: We will provide claim forms after We receive written notice of claim. Our usual claim forms will be provided. We will send the Insured these forms within 15 days after We receive his or her notice of claim. If We do not provide these forms within the allowed time, a claim can be filed without using them. The claim must contain written proof of loss. It must cover the occurrence, type and extent of loss. It must be provided within the time allowed in the next clause.

PROOF OF LOSS: The Insured must provide Us written proof of loss. It must be provided to Our Home Office within 90 days of the loss or as soon as reasonably possible. Proof provided more than one year late will not be accepted, unless the Insured had no legal capacity in that year.

TIME OF PAYMENT OF CLAIM: Benefits will be paid as soon as We receive due written proof of such loss.

PAYMENT OF CLAIMS: All benefits of the Policy, except benefits for loss of life, will be paid to the Insured. However, if the Insured is a minor or is otherwise not legally competent to give a valid release, We may pay any benefit then payable to the parent, parents, or legal guardian of the Insured, or other person actually supporting the Insured.

Unless a written request is received not later than the time for filing proof of loss, we may pay benefits directly to the hospital or person rendering service. It is not required that the services be rendered by a particular hospital or person.

Indemnity for loss of life is payable to the estate of the Insured, or at Our option, if the Insured is a minor, to the parent, parents, or legal guardian of the Insured. Payment so made will discharge Our liability with respect to the amount of insurance so paid. We do not assume any responsibility for the validity of an assignment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right and opportunity to examine the Insured while a claim is pending. These examinations will be made at Our expense and as often as we may reasonably require. We also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

LEGAL ACTIONS: No suit may be brought on a claim sooner than 60 days after the required proof of loss is given. No suit may be brought more than three years after the date proof of loss is required.

ENTIRE CONTRACT; CHANGES: This Policy including the Application and attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto.

No agent has authority to change this Policy or to waive any of its provisions. Any statement made by the Policyholder or by an applicant will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the insurance or reduce the benefits thereunder unless contained in the written Application.

TERMINATION, CANCELLATION, NONRENEWAL: If any premium is not paid before the expiration of the grace period, the Policy will terminate at the end of such period. If the Policy terminates during or at the end of such period, the Policyholder will be liable to the Company for the payment of such pro rata premium for the time the Policy was in force during such period.

Either We or the Policyholder have the right to terminate the Policy on any anniversary date. In such events the terminating party will mail to the other written notice of its intention not less than sixty days prior to such date.

Cancellation or expiration of the Policy for any cause will be without prejudice to any claim arising prior to termination.

CONFORMITY WITH STATE LAWS: The Policy will be governed exclusively by the laws of the state where it was delivered or issued for delivery. Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

POLICY PERIOD, RENEWALS: The Policy applies only to charges which are incurred during the Policy period while the Insured is insured, unless otherwise provided in the Policy. A charge will be deemed incurred on the date the charge producing service is performed. On each anniversary of the Policy effective date, as stated in the Application, the Policy is renewable, subject to Our consent, for an additional annual period by the payment of the renewal premiums then in effect.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

This Notice of Privacy Practices ("Notice") applies to Wellfleet Insurance Company and Wellfleet New York Insurance Company's (together, "we", "us" or "our") insured health benefits plans. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your "Health Information") is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. We gather this information from a variety of sources including your employer, your health care provider, your school, other insurers, and third party administrators (TPAs). This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may confirm enrollment in the health plan with the appropriate party.
- If you are a dependent of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- We may share enrollment information, payment information, or other Health Information in order to coordinate treatment or other services you may need.

We may disclose your information when instructed to do so, including:

- Health oversight activities may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- Legal proceedings may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- Law enforcement activities might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- As required by law or to avert a serious threat to safety or health; and,
- To certain government agencies, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the right to request restrictions on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the right to request that we communicate with you in certain ways.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor may have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the right to inspect and copy your Health Information in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the right to request an amendment to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an accounting of disclosures. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a right to receive a paper copy of this Notice. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the right to be notified of a breach of unsecure Health Information.

Finally, you have the right to file a complaint if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT
For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Wellfleet Insurance Company/
Wellfleet New York Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley ("GLB") Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* ("NPI"). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder's or contract holder's broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information ("PHI") unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as *Specially Designated Nationals* and *Blocked Persons.* This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)** 我們免費為您提供語言協助服務。請致電(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけ ます。(877) 657-5030 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. (877) 657-5030 تماس بگیرید.

कृपा ध्या दो: यदि आप हिन्दी (Hindi) भाषी हो तो आपके लिए भाषा सहायता सेवाएं निःशुल् उपलब् हो । कृपा पर काल करो (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- Accident, accident and health, or health insurance (including HMOs):
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- Life insurance:
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- Individual annuities: Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	Texas Department of Insurance P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). There may be other exceptions that aren't included in this notice. When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskCS@wellfleetinsurance.com
fax: (413) 733-4612

PLEASE FULLY COMPLETE THIS FORM

ATTACH ITEMIZED BILLS

MAIL ALL INFORMATION TO THE ABOVE ADDRESS

PART I – POLICYHOLDER'S REPORT

Participating Group Number:	Policyholder Number:	Policyholder Name:
SR510598K2	MP0000826022	LAKEHILL PREPARATORY SCHOOL

Claimant's Name (Injured Person)	E-Mail Address	Gender	Date of Birth	Event, Activity or Sport
		☐ M ☐ F		

Address of Injured Person and Best Contact Phone Number (Include Area Code) ( )

Address City State Zip Code

Date and Time of Accident	Place where Accident Occurred	The injured person was a:
		☐ Particpant ☐ Staff Member ☐ Other

Dental Claim	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident:
		☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured and left or right side– e.g. broken arm, sprained ankle, etc.)

Did Injury Result in Death? ☐ Yes ☐ No

Describe How Accident Occurred – Give All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? ☐ Yes ☐ No

B. On activity premises? ☐ Yes ☐ No

C. While traveling directly and uninterruptedly to or from the event? ☐ Yes ☐ No

D. During intercollegiate/scholastic athletic practice or competition? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge and belief, that the person named above is insured by the policy, and that his or her insurance was in effect on the date the accident occurred.

Signature of Plan Sponsor	Name, Title and Telephone Number of Plan Sponsor	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source?

☐ Yes ☐ No

If yes name of insurance company: _____ Policy #: _____

Other Insurance Carrier ID# _____ Other Insurance Carrier Telephone# _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ Yes ☐ No If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

I agree that should it be determined at a later date there is another insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

SIGNATURE _____ DATE _____

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ DATE _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to Wellfleet Group, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

I certify that the above information is correct to the best of my knowledge and belief. I understand that any person who knowingly and with the intent to defraud or deceive any
insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

Important Notice

- *In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:* 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.

- *For Residents of Alabama:* 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 restitution fines and confinement in prison, or any combination thereof.

- *For residents of Colorado:* It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- *For residents of the District of Columbia:* WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- *For residents of Florida:* 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.

- *For residents of Kentucky:* 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.

- *For residents of Maine, Tennessee, Virginia and Washington:* It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- *For residents of Oregon:* 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 may be guilty of a crime and may be subject to fines and confinement in prison.

- *For residents of Maryland:* Any person who knowingly or 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.

- *For residents of New Jersey:* Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- *For residents of New Mexico:* 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 CIVIL FINES AND CRIMINAL PENALTIES.

- *For residents of New York:* 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.

- *For residents of Ohio:* 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.

- *For residents of Oklahoma:* WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- *For residents of Pennsylvania:* 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.