SUMMARY OF COVERAGE

Coverage Period: 7/01/2015 – 7/01/2016
Carrier: Nationwide Life Insurance Company
AM Best Rated A+ XV

Excess Accident Medical Limits:
Maximum: $ 25,000 per injury
Usual & Customary 100%
Benefit Period: 1 Year
Deductible: $0 per claim
AD&SL $5,000
AD&SL Aggregate $250,000

Eligible Person:
All athletes participating in a Covered Activity.

Covered Activities:
Participating in practice or play of sports governed and/or sponsored by the Participating Organization.
Participating Organization: An organization which:
1. Elects to offer coverage under the Policy by completing a Participating Organization Application that has been accepted by Us (Nationwide);
2. Completes a participation agreement with the Policyholder; and
3. Remits the required Premium when due.

Definition of Injury
For the Accident medical Expense benefits, the following definition of Injury applies:
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 the Policy and while he or she is taking part in a Covered Activity.
3. Resulting in a concussion.

Definition of Concussion
A specific brain injury defined as a complex pathophysiological process affecting the brain, induced by trauma to the brain, and diagnosed by a Physician practicing within the scope of his or her license.

How to File a Claim

To process your claim, please submit the following pieces of information:

1. Completed and Signed 'K&K Incident Report'
2. Complete and Signed 'Other Insurance Questionnaire'
3. Itemized Bills
4. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed, emailed or faxed to:

K&K Insurance Group
Attn: Terri Bruner
1712 Magnavox Way
Fort Wayne, IN 46801

Terri.Bruner@kandkinsurance.com

(312) 381-9077 Fax
(800) 237-2917 Toll Free

The 'K&K Incident Report' enables the payer to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure to complete the 'Other Insurance Questionnaire'. The incident report must be signed by an MHSAA member school administrator.

Itemized Bills – please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account Statements or 'Balance Due' statements are helpful, but do not contain all the information needed to process the claim.

Explanation of Benefits – If you have other medical insurance, all medical bills first be submitted to that carrier for its determination of eligibility and payment. If the charges are not paid in full by the other medical insurance carrier, we will need to see a copy of the 'Explanation of Benefits' prior to paying any benefits. If you do not have other insurance, the need for an 'Explanation of Benefits' will not apply to your claim.

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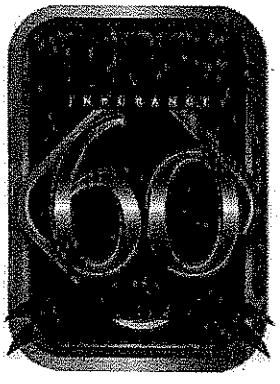

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

Michigan High School Athletic Association Concussion Coverage

MHSAA michigan high school athletic association

(PLEASE PRINT)

NATURE	❑ BODILY INJURY ❑ OTHER:_____
TIME & PLACE OF INCIDENT	DATE:_____ TIME:_____ ❑ AM ❑ PM EVENT NAME:_____ EVENT TYPE:_____ CONDUCTED BY:_____ LOCATION:_____
HAPPENED TO	NAME:_____ SSN:_____ DATE OF BIRTH:_____ SEX: ❑ Male ❑ Female PHONE: (____)_____ ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
FUNCTION	AS: ❑ ATHLETE ❑ OTHER:_____
APPARENT INJURY OR DAMAGE	BODY PART:_____ CONDITION:_____ ❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:_____ ❑ AMBULANCE, TAKEN TO:_____ CITY:_____ ❑ FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?_____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:_____
WITNESSES (If known)	NAME:_____ NAME:_____ ADDRESS:_____ ADDRESS:_____ PHONE: (____)_____ PHONE: (____)_____
INSURED	NAME OF INSURED:_____ POLICY#:_____ CLUB NAME:_____ PHONE: (____)_____ CITY:_____ STATE:_____
INSURED REPRESENTATIVE	❑ MHSAA Member School Administrator ❑ OTHER:_____ NAME:_____ PHONE: (____)_____ TITLE:_____ ORGANIZATION:_____ SIGNATURE:_____ DATE:_____

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

K&K INSURANCE

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT:_____ INTERNATIONAL STUDENT ❑ Yes ❑ No

EMANCIPATED STUDENT: ❑ Yes ❑ No

NAME OF INSURED:_____ POLICY NO:_____

FATHER

IS FATHER DECEASED? ❑ Yes ❑ No

IS FATHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

FATHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:____ ZIP:_____

POLICY NUMBER:_____

TYPE OF PLAN:
- ❑ HEALTH MAINTENANCE ORGANIZATION (HMO)
- ❑ PREFERRED PROVIDER ORGANIZATION (PPO)
- ❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ❑ OTHER (describe)_____

MOTHER

IS MOTHER DECEASED? ❑ Yes ❑ No

IS MOTHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

MOTHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:____ ZIP:_____

POLICY NUMBER:_____

TYPE OF PLAN:
- ❑ HEALTH MAINTENANCE ORGANIZATION (HMO)
- ❑ PREFERRED PROVIDER ORGANIZATION (PPO)
- ❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ❑ OTHER (describe)_____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE:_____ PARENT/GUARDIAN/MOTHER SIGNATURE:_____

DATE:_____ DATE:_____