Dunw vody Insurance Agency, Inc.
P O Bo: x 5125
Macon, GA 31208
Phone: 478-745-8681 Fax: 478-746-1416

MEMO

ACCOUNT NO.	OP	DATE
BIBBC-2	PM	09/21/2016

POLICY INFORMATION

POLICY #		
JXS0000027662700		
TYPE	EFFECTIVE	EXPIRATION
GROU	08/01/2016	08/01/2017

Bibb Co unty School District
Bibb Co unty Board Of Education
484 Mul berry St Ste 267
Macon, GA 31201

David Gowa n **Re: Renewal policy enclosed**

I am ver y pleased to enclose the renewal of the above cap ttioned policy. Please r eview it carefully payin g particular attention to coverages, limits, deductibles, and exclusi ons. If any changes or co rrections are necessar y, please notify me righ t away.

We appre eciate your continued bus iness and look forward to working with you agai n this year.

Thank yc ou,

Bonnie M dullis

bm/pm

000299086 / JXS0000027662700

K&K INSURANCE

SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

Nationwide®

STUDENT OR ATHLETE ACCIDENT CLAIM FORM
Excess Coverage
K-12 ACCOUNTS

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 Fax: 312-381-9077 California License #0334819
www.kandkinsurance.com

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I -- TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: _____ First: _____ MI: _____
   Date of Birth: _____ SS# _____ Sex: O Male O Female
3. Student's grade in school: _____
4. Home Address Street: _____
   City: _____ State: _____ Zip: _____
   Parent(s)/Guardian(s) Home Phone: _____
5. Date of Accident: _____ Time of Accident: _____ O AM O PM
   Nature of Injury: _____ Describe exactly how accident happened: _____
6. Nature of activity and location during which the injury occurred (check all boxes which apply):
   - O Pre-K Kindergarten
   - O Elementary School
   - O Middle School
   - O High School
   - O Cafeteria
   - O Classroom Activities
   - O Interscholastic Sports
   - O Intramural Sports
   - Name of Sport, if applicable: _____
   - O Club Sports
   - O Physical Education Class
   - O Other Activity (specify) _____
   - O During Practice
   - O During Play
   - O During Travel To or From the Event

   Nature of Your Participation:
   - O Student
   - O Volunteer
   - O Student/Manager
   - O Athletic Participant
   - O Cheerleader
   - O Band Member
   - O Other (specify) _____
7. Transfer Student? O Yes O No
   If yes, please identify the former school name: _____
8. Name, address and phone number of physician who first treated you: _____

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9. Have yo uu had a similar injury in the past? O Yes OO No
   If yes, d eescribe and give dates: _____
10. Name, a ddress and phone number of physician who trreated you for previous injury: _____
11. Are you ccovered by any other medical expense benei tfits plan? O Yes O No
    If yes, gi vve the names of the plan(s) and the person(s)) through whom you are insured and their rel aationship to you:

IF YOU HAVE N NO OTHER INSURANCE ON YOUR CHILI D, BUT YOU AND/OR YOUR SPOUSE ARE E EMPLOYED FULL TIME, PLEASE PROVIDE A S TTATEMENT FROM THE EMPLOYER(S) IN DICATING YOUR CHILD IS NOT COVERE D BY ANY INSURANCE OFFERED THERE.

ALL BENEFIT SS WILL BE MADE PAYABLE TO PROVIDE RRS OF SERVICE INVOLVED, UNLESS ACC COMPANIED BY PAID RECEIPTS.

THIS IS EXCE SS MEDICAL COVERAGE

I hereby autho irize any physician, hospital, or other medical lly related facility, insurance company, or oth eer organization, institution or person that has any rrecords of knowledge of me, and/or the aabove named claimant, to disclose, wher eever requested to do so by K&K Insurance/Spe cialty Benefits and/or Nationwide Life Insura nce Company or its representative, any and aall such information. A photocopy of this authorizati on shall be considered as effective and valid as the original.

Any person wh oo knowingly and with intent to defraud any i nsurance company or other person files clain n forms for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact r material thereto commits a fraudulent insurance act, which is a crime.

Date _____ _____ Parent/Guardian Sign ature _____ _____

CTION II (TO BE COMPLE TED BY PARTICIPATING SCHOOL)

FAILURE TO C OMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESS ARY DELAY IN THE PROCESSING OF T THIS CLAIM.

1. Student' ss Name Last: _____ First: _____ MI: _____
2. Date of A Accident _____
3. Activity _____
4. Nature o f Injury _____
5. Name o f Participating SCHOOL SYSTEM or SCHOC L DISTRICT _____
6. Name o f participating SCHOOL _____
7. I hereby c certify the foregoing statements made by me e on this form to be true to the best of my kno wledge. I am aware that if any of the foregoin gg statements on this form made by me are w illfully false, I may be subject to penalties, wh ich may include criminal prosecution.

SIGNAT URE OF SCHOOL OFFICIAL: _____

PRINTE D NAME/TITLE: _____

PHONE : _____ FAX: _____

EMAIL: _____ DATE: _____

Any person wh no knowingly and with intent to defraud an y insurance company or other person files fi forms for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact r material thereto commits a fraudulent insurance act, which is a crime.

Date _____ _____ Policyholder (School O Official) Signature _____ _____

000299086 / JXS0000027662700

OTHER INSURANCE QUESTIONNAIRE

K&K INSURANCE
CLAIMS DEPARTMENT
1712 Magnavox Way, P. O. Box 23 338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 | Fax: 312-381-9 0077 California License #0334819
www.kandkinsurance.com

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT O Yes O No

EMANCIPATED STUDENT: O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT : O Yes O No

NAME OF INSURED: _____ POLICY NO: _____

	FATHER	MOTHER
IS DECEASED?	O Yes O No	IS MOTHER DECEASED? O Yes O No
IS LEGALLY RESPONSIBLE?	O Yes O No	IS MOTHER LEGALLY RESPONSIBLE? O Yes O No
NAME (if injured is a minor)		MOTHER'S NAME (if injured is a minor)
SOCIAL SECURITY #		SOCIAL SECURITY #:
EMPLOYED?	O Yes O No SELF-EMPLOYED? O Yes O No	EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?	O Yes O No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No
EMPLOYER NAME		EMPLOYER NAME:
EMPLOYER ADDRESS		EMPLOYER ADDRESS:
CITY	STATE: ZIP:	CITY: STATE: ZIP:
PHONE: ( )		PHONE: ( )
CONTACT PERSON		CONTACT PERSON:
Do you have group medical insurance coverage through your employment?	O Yes O No	Do you have group medical insurance coverage through your employment? O Yes O No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.		If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY		INSURANCE COMPANY:
INSURANCE COMPANY ADDRESS		INSURANCE COPANY ADDRESS:
CITY	STATE: ZIP:	CITY: STATE: ZIP:
POLICY NUMBER		POLICY NUMBER:
TYPE OF PLAN:	O HEALTH MAINTENANCE ORGANIZATION (HMO) O PREFERRED PROVIDER ORGANIZATION (PPO) O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE O OTHER (describe)	TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO) O PREFERRED PROVIDER ORGANIZATION (PPO) O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES O 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: _____

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FACTS	WHAT DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number, government issued identification, and contact information • Policy, account, and contract information • Credit reports and other consumer reports
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
For our everyday business purposes— to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

To limit our sharing	• Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices. • If you have previously opted out, your preference remains on file and you do not need to opt out again. • Please have your account or policy number handy when you call. **Please note**: If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	1-800-237-2917

Who we are	
Who is providing this notice?	Nationwide Life Insurance Company
What we do	
How does Nationwide protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.

How doe ss Nationwide collect my personal i information?	We ccollect your personal information, for example, when you: • AApply for insurance • MMake a payment or file a claim • CConduct business with us We also collect your personal informa tition from others, such as crec lidit bureaus, affiliates, or other compa nnies.
Why can' t I limit all sharing?	Fed eeral and state law gives you the right t to limit only: • SSharing for affiliates' everyday busir eess purposes—information aabout your creditworthiness; • AAffiliates from using your information t to market to you; and • SSharing for nonaffiliates to market to yyou. Stat ee laws and individual companies ma yy give you additional rights to li mit sharing. See below for more infor mation.

Definitio ns

Affiliates	Con npanies related by common ownersl nip or control. They can be fina ncial and nonfinancial companies. These companies include Nati onwide Life Insurance Company , Nationwide Bank, and Nati onwide Property and Casualty I nsurance Company. Visit nati onwide.com for a list of affiliated com panies.
Nonaffilia ttes	Con npanies not related by common own ership or control. They can be fi rinancial and nonfinancial companies.
Joint mar keting	A fo rmal agreement between nonaffiliate ed financial companies that toge ther market financial products or ser vices to you.

Other imp portant information

alifornia I Residents: We currently do not sha are information we collect about you with affiliated or nonaffiliated companies f for their marketing purposes. Therefore, you do not need to opt out.

Nevada R esidents: You may request to be plac ed on our internal Do Not Call list. Se nd an email with your phone number to privacy@nationwide.com. You may req uest a copy of our telemarketing practic ees. For more on this Nevada law, contac t Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3 132; email: BCPINFO@ag.state.nv.us.

Vermont R esidents: For Vermont customers only. We will not share your personal inform nation for marketing purposes with the Na tionwide family of companies or third par ties without your authorization, except as s permitted by law.

AZ, CA, C T, GA, IL, ME, MA, MT,NV, NJ, NM, NC , ND, OH, OR, and VA Residents: Whe n we refer to "Information" we mean infor mation we collect during an insurance t ransaction (not including medical record l information). We will not use your medic al information for marketing purposes w ithout your consent. We share personal l information with nonaffiliates without you r prior authorization as permitted or re quired by law. They may use it to inves tigate fraud, respond to court orders, and conduct actuarial studies. We share it with insurance regulatory authorities an d law enforcement. We share it with cons umer reporting agencies. They may re tain it or disclose it to other companies with which you do business. These othe r companies use and disclose it to othe rs as permitted by law. We obtain repo rts prepared by an insurance-support org anization. The insurance-support orga nization keeps copies and discloses thei m to others. You have a right to access a nd correct your Information as describec l below.

Accessing your information

You can as k us for a copy of your personal inform ation. Please send your request to the address below and have your signature n otarized. This is for your protection so we may prove your identity. Please incl ude your name, address, and policy numl oder. You can change your personal infor mation at Nationwide.com or by calling your agent. We can't change information t that other companies, like credit agencie es, provide to us. You'll need to ask ther n to change it.

K& KK Insurance Group, Inc.
A Attn: Privacy Manager
1712 Magnavox Way
P.O. Box 2338
For t Wayne, IN 46801-2338

Nationwide L ife Insurance Com pany

Home Office: Columbu ss, Ohio

Nationw ide®

Blanket Accident Insurance Policyholder Application

(Print or type o nly)

1. Policyholc der Information

Policyholc der Name		Policy I Number
BIBB COU NTY SCHOOL DISTRICT		JXS0(000027662700
Location / Address 484 MULE BERRY STREET, SUITE 485 MACON, (GA 31201		
Mailing Ac ddress (if different from above)	City State Zip	County
Phone ( )	Administrative Contact	
Fax ( )	Title	
Effective I Date (MM/DD/YYYY) 08/01/16	Email Address	

2. Premium I Payment

It is unders tood and agreed that premiums are due aand payable as agreed upon by the Polic yholder and the Company.

3. General C onditions

n applying f for the Benefits set forth herein, the und ersigned understands and agrees that:

.. All nec essary administrative information concer rning all Insured Persons shall be subjec t to the provisions of the Policy and sh all be maintained by the [Policyholder, P. articipating Organization].

2. This A pplication is subject to the approval of N ationwide Life Insurance Company at it s Home Office and that nothing contair ned herein shall be binding upon said Co mpany until this Application has been so approved.

3. All ber efits will be in accordance with the be nefits proposed and agreed upon betw een Nationwide Life Insurance Compa ny and the Policyholder as set forth in th e Policy, subject to the Policyholder's ap proval.

State Frau dd Notices

(California)) For your protection California law rec quires the following to appear on this for m. Any person who knowingly presents a false or fraudulent claim for the payr ment of a loss is guilty of a crime anc may be subject to fines and confinemer ht in state prison.

(District o f Columbia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an applica tion for insurance is guilty of a crime ai nd may be subject to fines and confinemer ht in prison.

(Florida) A ny person who knowingly and with inten t to injure, defraud, or deceive any insur aance company files a statement of claim or aan application containing any false, inco mplete, or misleading information is guilt y of a felony of the third degree.

(Kentucky)) Any person who knowingly and with intent to defraud any insurance com pany or other person files an application f for insurance containing any materially false information or conceals, for the pur pose of misleading, information concerning any fact material thereto commits a frau dulent insurance act, which is a crime.

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

(Maine) Ar y person who knowingly and with intent t to defraud any insurance company or o ther person, files an application for insuran ce or statement of claim containing any materially false information or conceals for the purpose of misleading, formation concerning any fact material thereto c ommits a fraudulent insurance act, whic h is a crime and subjects such person to c riminal and/or civil penalties.

(Maryland) 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.

(Missouri) An insurance company or its agent or representative may not ask an applicant to omit 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.

(NAIC) 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.

(New Hampshire) The policy provides limited benefits. Review your policy carefully.

(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.

(New Mexico) 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.

(Oklahoma) 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.

(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.

(Puerto Rico) 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 aggravated 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.

(Washington) 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.

(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.

Please Sign & Date

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

Agent's Signature		Signature of Applicant	
Agent's Printed Name and Number K&K INSURANCE GROUP INC 13-0090572		Printed Name of Applicant and Title	
Agent's Phone Number		Applicant's Phone Number	
Agent's E-mail Address		Applicant's E-mail Address	

Nationwide L iife Insurance Com pany

Home Office: Columbu ss, Ohio

Nationw iide®

Blanket Accident Insurance Policyholder Application

(Print or type o nly)

1. Policyholc der Information

Policyholc der Name BIBB COU NNTY SCHOOL DISTRICT		Policy I Number JXS0C 000027662700	
Location A ddress 484 MULB BERRY STREET, SUITE 485 MACON, (GA 31201			
Mailing Ac ddress (if different from above)	City	State Zip	County
Phone ( )	Administrative Contact		
Fax ( )	Title		
Effective D ate (MM/DD/YYYY) 08/01/16	Email Address		

2. Premium P ayment

It is underst ood and agreed that premiums are due a nnd payable as agreed upon by the Polic yholder and the Company.

3. General Cc nditions

' applying f dor the Benefits set forth herein, the unde rsigned understands and agrees that:

.. All nece essary administrative information concer hing all Insured Persons shall be subject t to the provisions of the Policy and sha ll be maintained by the [Policyholder, Pa rticipating Organization].

2. This Ap plication is subject to the approval of N ationwide Life Insurance Company at its l Home Office and that nothing contain ed herein shall be binding upon said Con mpany until this Application has been so a pproved.

3. All ben efits will be in accordance with the ber efits proposed and agreed upon betwe een Nationwide Life Insurance Compar ny and the Policyholder as set forth in the e Policy, subject to the Policyholder's app proval.

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(Florida) An y person who knowingly and with intent to injure, defraud, or deceive any insura nce company files a statement of claim or a n application containing any false, incom plete, or misleading information is guilty of a felony of the third degree.

(Kentucky) Any person who knowingly and with intent to defraud any insurance comp any or other person files an application f or insurance containing any materially fa lse information or conceals, for the purp ose of misleading, information concerning a ny fact material thereto commits a fraud ulent insurance act, which is a crime.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of d efrauding the company. Penalties may i nclude imprisonment, fines or a denial of insurance benefits.

(Maine) Any person who knowingly and with intent to defraud any insurance company or oth er person, files an application for insurance or statement of claim containing any m aterially false information or conceals f or the purpose of misleading, information c oncerning any fact material thereto com mits a fraudulent insurance act, which is a crime and subjects such person to cri minal and/or civil penalties.

(Maryland)) 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 informati on in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Missouri) 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.

(NAIC) 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.

(New Hampshire) The policy provides limited benefits. Review your policy carefully.

(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.

(New Mexico) 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.

(Oklahoma) 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.

(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.

(Puerto Rico) 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 aggravated 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.

(Washington) 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."

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(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.

Please Sign & Date

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

Agent's Signature		Signature of Applicant	
Agent's Printed Name and Number K&K INSURANCE GROUP INC 13-0090572		Printed Name of Applicant and Title	
Agent's Phone Number		Applicant's Phone Number	
Agent's E-mail Address		Applicant's E-mail Address	

SCHEDULE OF BENEFITS

This Schedule of Benefits shows highlights of the coverage available under the Policy. Final interpretation of all provisions and coverages will be governed by the Policy on file with Nationwide Life Insurance Company.

Policyholder: BIBB COUNTY SCHOOL DISTRICT

Policy Number: JXS000002766 22700

Policy Effective Date: 08/01/16

Policy Termination Date: 08/01/17

Policy Term: 08/01/16 - 08/01/17

Eligible Class(es):

Class	Number of Eligible Persons	Description of Eligible Persons	Effective Date	Termination Date
1	2,000	Students of the Policyholder in grades 9 through 12.	08/01/16	08/01/17

Covered Activities:

Class	Description of Activities
1	All interscholastic athletics and extracurricular activities conducted by the Policyholder.

NOTE: The Maximum amounts below are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

ACCIDE	NT MEDICAL EXPENSE BENEFIT		Class 1	
Maximum	n Benefit Amount:		$25,000 Per Insured	l Per Injury
Deductibl	ee:		$0 Per Insured Per I	njury
Benefit P	ercentage:		100% of R&C	
Loss Peri	od:		60 days	
Benefit P	eriod:		1 year	
Note: Th	sis Benefit is subject to the Exclusions an	dd other provisions of the Policy. In addit	ion, the following limitations	
apply. Be	enefits for Covered Expenses shown bel	ow are subject to the Maximum Benefit A	Amount, Deductible, Benefit	
Percenta	ge, Loss Period, and Benefit Period sh	own above, unless otherwise specified.	Benefits sub-limits shown	
below are	per Insured Person per Injury, unless o	therwise specified.		
Cove	**red Expenses:**		**Benefit Sub-Limit**	**s:**
Inpat	**ient Hospital Services**			
R	oom & Board – Semi-Private		80% of R&C	
H ca da	ospital Miscellaneous Expense (including are and pre-admission testing performed ays prior to admission)	g general nursing within 3 working	Maximum $1,200 pe	r day
R or	egistered Nurse Services (private duty n dered by a licensed Physician)	ursing care when	100% of R&C	
Emer room	gency Room Services (including use of t and supplies)	he emergency	Maximum $300, if re	ndered within 72 hours of injury
Phys	**ician Services**			
Pl	hysician Non-Surgical Services		$60 first day/$40 ea	subsequent day limited to one visit p	er day
Pl	hysician Surgical Services, Inpatient or C	Outpatient	Maximum $1,200, li	mited to primary procedure per injury	
C at	onsultant Physician, when requested and tending Physician	approved by the	Maximum $400	
A	ssistant Surgeon		25% of surgery allov	vance
A ar	nesthetist Services (not including superv nesthetist)	ision of an	25% of surgery allov	vance
Day S servic	Surgery Miscellaneous (including supplie ees in connection with scheduled outpatie	s, drugs and ent day surgery)	Maximum $1,200	
X-Ra	y Services		Maximum $600	
Diagn	ostic Imaging Services		Maximum $600	
Labor	atory Services		Maximum $300	
Comb	ined Ground and Air Ambulance Servic	es	Maximum $800	
Orthc	pedic Braces and Appliances		Maximum $140	
Denta	l Services		Maximum $500 per	tooth
Outpa	tient Physical Therapy		$60 first day/$40 ea day/5 day maximum visit per day.	subsequent , limited to one
Presc	ription Drugs		Maximum $200/30 d	lay supply per scrip

Expe	nses for the following are not covered	:	Prosthetic Devices, I Disorder, Home Hea Injections	Mental & Nervous lth Care,

R&C = Re easonable Charges

ACCIDEI	NTAL DEATH AND SPECIFIC LOSS BE	NEFIT	Class 1	
Aggregat	e Limit of Liability:		$500,000	
Accidenta	l Death Principal Sum:		$10,000	
Specific L	oss Principal Sum:		$10,000	
See the S	pecific Loss Benefit Provision in the Poli	cy for any applicable benefit reduction in	the Principal Sum.	

RIDERS A ATTACHED AT ISSUANCE: | **Form Number:** | **Applicable to Class:**

Riders atta ached to this Policy will provide the cover age described in the Rider at the benefit l levels shown in the Rider.

EXCESS E BENEFITS RIDER | NSHBA 2400 EXC A | All Classes

NSHBA 22500 SCHED B

Natio nnwide®

Nationwide Life In: ssurance Company
Home Office: One I Nationwide Plaza, Columbus, , Ohio

BLANKET ACCIDE ENT POLICY

INS SURING AGREEMENT

This P olicy is issued in consideration of the Ap plication made by the Policyholder. We promise to pay, subject to the Po licy Terms, the Benefits stated herein. V We make this promise and issue this Pol icy to You in exchange for the Pr emium shown in the Schedule of Ber efits. The Policy insures only those p ersons referred to in the Sched ule of Benefits for whom proper Premiu m has been paid. This Policy is a legal contract between You and Us.

POLICY TERM

The P olicy Term starts at 12:01 a.m. standard ti time at Your address on the effective da tate shown in the Schedule of Ben efits. This Policy is a non-renewable tern n blanket Policy.

NOTICE

PLEA SE READ YOUR POLICY CAREFULL Y. THIS IS LIMITED INSURANCE. IT IS AN ACCIDENT ONLY POLIC CY AND DOES NOT COVER LOSS (OR EXPENSES RESULTING FROM S ICKNESS, DISEASE OR BODI LY INFIRMITY.

Signe d for Nationwide Life Insurance Comp any

Secretary

P resident

TABLE OF CONTENTS
(Benefits apply only as shown in the Schedule of Benefits.)

DEFINITIONS

General Definitions

Accident or Accidental: A specific unforeseen event:

1. that is sudden, unexpected, and unintended, over which a Insured Person has no control and which happens while the Insured Person is covered under this Policy; and
2. which directly, and from no other cause, results in an Injury; and
3. that is independent from Sickness, disease, bodily infirmity, or illness.

Aggregate Limit of Liability: The Aggregate Limit shown in the Schedule of Benefits is the maximum amount payable by Us for all Claims incurred for all Insureds under the Policy which are caused by any one Accident that occurs when the Policy is in force. If this limit is not sufficient to pay the total of all such Claims, the Benefit payable to any one Insured will be determined in proportion to our total aggregate limit of liability. This Aggregate Limit of Liability applies only to Accidental Death and Specific Loss and related Benefits.

Application: The attached Policy application, including any amendments, which is a part of the Policy.

Beneficiary: The one who will receive Benefits payable upon the Insured Person's death. The Insured may designate or change the Beneficiary at any time by filing written notice on a form We provide and sending it back to the Policyholder or Our Agent or Us.

Benefit: The dollar amount payable by Us to a Claimant or Beneficiary under the Policy.

Benefit Period: The period of time during which Covered Expenses must be incurred in order for benefits to be payable, as shown in the Schedule of Benefits or applicable Riders. A benefit period starts on the date of the Covered Accident and ends at the end of the time period shown as the Benefit Period, unless specified elsewhere in the Policy.

Claim: A request for payment of Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as the Insured Person (Insured's parent, if a minor), the Insured's legal guardian, the Beneficiary, or a person representing any of the above.

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

Coverage: The right of the Insured Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

Covered Activity(ies): The covered event or activities described in the Schedule of Benefits.

Effective Date: The date on which insurance Coverage begins under the Policy.

Eligible Class: A group of people who are eligible for Coverage under the Policy as listed in the Schedule of Benefits.

Eligible Person: A person who belongs to an Eligible Class as described in the Schedule of Benefits.

Family Member: A person who is related to the Insured Person in any of the following ways: spouse, domestic partner, common law spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), legal guardian, brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Insured Person's household.

Health Care Facility: A Hospital, Skilled Nursing, Sub-Acute, hospice, or other duly licensed, certified, and approved health care institution that provides care and treatment for sick or injured persons.

Heart and Circulatory Malfunction: A sudden and serious malfunction of the heart or circulatory system, which includes myocardial infarction, cardiac arrest, heart attack, heat exhaustion, coronary thrombosis, cerebral vascular accident (e.g., stroke or aneurysm), and does not include conditions such as hypertension or angina.

Independent Medical Exam: An examination by a Physician of the appropriate specialty for an Insured Person's condition at Our expense. Such examination, scheduled by Us, may be used for the purpose of determining eligibility for insurance or Benefits, including eligibility under the Rider, if any, associated with the Policy.

Incident: Any one event or series of events related to the cause or causes which result in the Loss.

Injury or Injuries: 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 this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:
1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries or aggravation of such injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered as one Injury.

Insured Person or Insured: An Eligible Person insured under the Policy.

Loss Period: The period of time within which the first expense must be Incurred following an Accident for Benefits to be payable for the Injury sustained.

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;
2. completes a participation agreement with the Policyholder; and
3. remits the required Premium when due, if applicable.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:
1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and exclusions regarding Coverage.

Policy Term: The period of time the Policyholder is covered by the Policy. The Policy Term is shown in the Schedule of Benefits.

Policyholder: The organization who has contracted with Us to provide Benefits to the Insured Person. To the extent that a Participating Organization is applicable, the term Policyholder can be deemed to include the Participating Organization(s), unless otherwise specified in the Policy.

Premium: The periodic fee required to maintain Coverage for each Insured Person in accordance with the terms of the Policy.

Proof: Evidence satisfactory to Us that a person has satisfied the conditions and requirements for a Benefit.

Provider: Any Physician, health professional, Health Care Facility or other person or recognized entity licensed to provide medical services to Insured Persons.

Schedule of Benefits: Shows the amount of Benefits provided under this Policy.

Sickness: An illness, disease or condition, including the pregnancy, childbirth and unrelated medical conditions of an Insured Person, that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident.

Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.

We, Our, Us and **Insurer**: The insurer, Nationwide Life Insurance Company.

Written or **Writing**: A record which is on pr transmitted by paper or electronic me ddia which is acceptable to Us and consistent with applicable law.

You and **Your:** The plan sponsor or Policy nholder named in the Schedule of Benefit ss.

Other terms are defined elsewhere under the P olicy.

Additional **Definitions for the Accident Medi**cal Expense Benefit and any applicab**le Riders**

Arnbulance **Services:** Professional grou nd and air Ambulance Services to trar nsport the Insured Person fro m the place where the Covered Accide nt occurred to the nearest medically ap propriate facility; and from the e nearest medical facility to another appr opriate medical facility, if a Physician sp ecifies in writing that such tra nsport is Medically Necessary.

Chiropractic **Services:** Includes all thera peutic, adjustment, and manipulation se rvices and modalities (i.e., ho t packs, cold packs and ultrasounds, e tetc.) administered by a Provider acting within the scope of their lic ense.

Confinement/**Confined:** An uninterrupte d stay following admission to a Health n Care Facility due to an Ac cidental Injury. The re-admission to a H ealth Care Facility for the same or relate d Accidental Injury, within a 72-hour period, will be considered a conti nuation of the same period of confineme nt. Confinement/Confined do es not include observation, which is the r review or assessment, of less than 24 h hours, of a person's Injury tha t does not result in admission to a Health n Care Facility.

Custodial **Care:** A level of routine maint enance and supportive care that is pri marily for the purpose of att ending to the activities of daily living f or which the services of a skilled profe ssional are not Medically Ne cessary. Custodial Care includes, but is not limited to, assistance in walking , getting in or out of bed, ba thing, dressing or grooming, feeding, tak ing medicine, exercise, or entertainment t. Custodial Care may not be provided by the Insured Person's Famil y Member unless specifically agreed to i n writing by Us. Custodial Ca re does not include Home Health Care s ervices or treatment.

Deductible: The amount of Covered Expe nse that must be Incurred by the Insure d before any Benefits are pa yable by Us. The Deductible will apply a s specified in the Schedule of Benefits o r any endorsements to this Po licy.

Deductible **Incurral Period**: The period o f time, starting on the date of the cove ered Accident, within which the Insured must satisfy the Deductible b efore Benefits will be payable for subse quent Covered Expenses Inc urred as a result of the Accidental Injury .

Diagnostic **Imaging:** Those forms of radio graphs that are not plain film radiography r (x-rays). It includes but is no t limited to: computerized axial tomograp hy (CAT); magnetic resonance imaging (MRI); radionuclide imaging (nu clear medicine) and ultrasound (US). These examinations may be performe d with or without contrast ma terials.

Durable **Medical Equipment:** A device wh ich:

1. is primarily and customarily used l for medical purposes, is specially eq uipped with features and functions that are generally not re quired in the absence of Injury and is a ble to withstand repeated use;
2. is used exclusively by the Insured;
3. is routinely used in a Hospital but c an be used effectively in a non-medical f acility;
4. can be expected to make a meanir gful contribution to treating Insured's Inj ury; and
5. is prescribed by a Physician and is M Medically Necessary for rehabilitation.

Expenses **Incurred:** See Incurs or Incurre d.

Home **Health Aide:** A person who provid es care of a medical or therapeutic natu re and who reports to, and is under the direct supervision of, a Home H Health Care Agency.

Home **Health Care Agency:** A business t that provides Home Health Care Servic es and is licensed by the ap propriate state licensing authority.

Home **Health Care Services:** The provi sion of a health service for payment o r other consideration in a pa tient's residence, instead of an otherwis e required Hospital or nursing home co nfinement, under a plan of ca re established, approved in writing, an d reviewed and certified at least once every two months by the att ending Physician as necessary for medic al purposes. Home Health Care Servic es includes:

1. part-time or intermittent skilled nurs ing services provided by a Nurse;
2. part-time or intermittent Home He alth Aide services which provide suppo rtive services in the home under the supervision of a registere d Nurse or a physical therapist;

3. Physical, respiratory, occupational, and speech therapy; and
4. the furnishing of medical equipment supplies other than drugs and medicine ss.

Each visit by a Nurse or Home Health Care Agency employee constitutes a Home Health Care visit and each four hours of Home Health Aide services constitutes a Home Health Care visit. If services extend beyond four hours, each four hours or portion of that period is considered as one Home Health Care visit. Home Health Care Services does not include Custodial Care services or treatment.

Hospital: An institution that:
1. operates pursuant to law; and
2. has 24 hour nursing services by registered Nurses; and
3. has a staff of one or more doctors; and
4. provides inpatient therapeutic and diagnostic services for Injury or Illness; and
5. provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
6. is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); or
7. is approved by the American Hospital Association (AHA); or
8. is approved by the American Osteopathic Healthcare Association (AOHA); or
9. is approved by the American Osteopathic Association accreditation (AOA); or
10. is approved by the Commission on AAccreditation of Rehabilitation Facilities (CCARF).

Unless otherwise provided in the Policy, Hospital does not include any of the following:
1. A rest or nursing home, home for the aged or convalescent home; or
2. A Skilled Nursing Facility; an extended care facility; or
3. A hospice or a place for Custodial Care; or
4. A birthing center.

Incurs or Incurred: Covered Expenses for:
1. services and treatments actually received within the applicable Benefit Period; and
2. medical supplies actually purchased, received, and utilized within the applicable Benefit Period. The terms "Incurs" and "Incurred Expenses" do not include expenses deferred beyond the applicable Benefit Period.

Inpatient: Confinement of 24 hours or greater.

Loss: Medical Expenses Incurred that are caused by Injury and which are payable under the Policy's terms and Conditions.

Medically Necessary: Services or supplies that are:
1. appropriate and necessary for the symptoms, diagnosis, or treatment of the Injury;
2. provided for the diagnosis or direct care and treatment of the Injury;
3. consistent with generally accepted professional standards of care within the organized medical community;
4. not primarily for the convenience of the Insured Person or Insured Person's Physician, or another health care Provider; and
5. the most appropriate supply or level of service which can safely and effectively be provided.

Mental and Nervous Disorders: Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and its successor, as a mental disorder on the date of medical care or treatment is rendered to an Insured Person by a Physician and to the extent that the mental or nervous disorder is a result of a covered Accidental Injury as determined by a Physician.

Nurse: A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who:
1. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices;
2. provides medical services which are within the scope of the nurse's license or certificate;
3. is not a Family Member of the Insured Person; and
4. is not a person employed or retained by the Policyholder.

Outpatient: Care or treatment received from a Provider to which the Insured Person is not admitted.

Physical Therapy: Includes but is not limited to acupuncture, physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, or massage administered by a Provider acting within the scope of their license. Physical Therapy does not include Chiropractic Services.

Ph ysician Services: Services provided b vy a Physician, including expenses for s urgery, assistant surgeon, co nsultations or second opinions, Physiciar 's visits, and anesthesia and its adminis rtration.

Pr escription Drug: A drug which has be een determined to be safe and effectiv ee by the Food and Drug Ad ministration and which can, under federa al or state law, only be dispensed when c ordered by a Provider who is c duly licensed to prescribe such medicatio nn.

Sk illed Nursing Care: Services that ar ee certified as Medically Necessary by a a Physician and are not inte ermediate, domiciliary, Custodial or retire nment care.

So und Natural Tooth: A tooth which can v withstand normal chewing forces, and ha ss:

1. normal, healthy periodontium; and
2. adequate healthy dentin; and
3. adequate enamel.

A S Sound Natural Tooth includes a natura l tooth that has been restored by amal ggam (or similar process), cro wn, inlay or onlay.

Su b-Acute Facility: A free-standing facil tity or part of a Hospital that is certifie dd by Medicare to accept pat ients in need of rehabilitative and Skilled l Care Nursing.

Re asonable Charge (R&C): The most co mmon charge for similar professional se rvices, drugs, procedures, de vices, supplies or treatment within the a area in which the charge is incurred. T The most common charge me ans the lesser of:

1. the actual amount charged by the F Provider; or
2. the negotiated rate, if any; or
3. the fee most often charged for in th ee geographical area where the service w as performed.

Th ee Reasonable Charge is determined b y comparing charges for similar service es to a national database adj usted to the geographical area where th ee services or procedures are performec l, by reference to the 75th per centile of FairHealth schedules. The In ssured Person may be responsible for th ne difference between the Re asonable Charge and the actual charge f from the Provider.

ADMIN ISTRATIVE PROVISIONS

Premi ium

The Pr emium rates, and the method and timir gg of premium payments, are as agreed upon by the Policyholder and Us . Premiums must be paid to Our Home Office or to one of Our representatives.

Policy Terminations

This Pc olicy can be terminated at any time by wi ritten notice mailed or delivered by Us to t the Policyholder or by the Policyh older to Us. Such notice must be provid ded at least 60 days in advance of the ter mination date.

If the P Policyholder terminates the Policy, termir nation will become effective at 12:01 a.m. local time, based on the Policyh older's address, when We receive notice e or the date specified in the notice, whic hever is later.

In eith er event, We will promptly return any u nearned Premium paid or the Policyhol der will promptly pay any earned Premium which has not been paid.

Neithe r termination of the Policy nor termination of the Insured Person's coverage unde r the Policy shall prejudice the set tlement of any Claim for Loss where the Accident precipitating the Loss occurre d on or before the date of termin ation.

Term of an Insured Person's Coverage

A pers on's coverage begins on the later of:

1. the Effective Date of the Policy; or
2. the Effective Date of the Participating C Organization, if applicable; or
3. when he or she becomes an Eligible Pe erson.

An Insu ured's coverage ends on the first of these e to occur:

1. when he or she is no longer an Eligible F Person; or
2. the end of the last day for which Premiu ium has been paid; or
3. the date the Insured dies; or
4. the termination date of the Participating Organization, if applicable; or
5. the termination date of the Policy.

Termir nation will not affect a Claim which occurs before the coverage ends.

BE NEFIT PROVISIONS

Maxim uum Benefit Amounts

The Ma aximum Benefit Amounts which apply to a aan Insured Person are shown in the Sch edule of Benefits.

ACCIC BENT MEDICAL EXPENSE BENEFITS

If, as a a result of an Accidental Injury which o ccurs while participating in a Covered A Activity, an Insured incurs Covere ed Expenses during the Benefit Period sp eecified in the Schedule of Benefits, we w illill pay:

1. Covered Expenses Incurred that excee dd any applicable Deductible, specified in t the Schedule of Benefits; and
2. as long as the first expense has bee nn Incurred within the Loss Period spe ccified in the Schedule of Benefits; and
3. until the total paid for Covered Expense es Incurred equals any applicable Benefi t t percentage, Benefit sub-limit, or maximum shown in the Schedu ele of Benefits; or
4. until the end of the Benefit Period show m in the Schedule of Benefits; or
5. until Benefits paid equal the Maximum EBenefit Amount for the Accident Medica l Expense Benefits shown in the Schedule of Benefits.

Covere ed Expenses for this Benefit means th ee Medically Necessary and Reasonab le Charges for services, supplie es, and treatment provided or prescribe d by a Physician for which an Insured P erson is required to pay, except as may be limited in the Schedule of EBenefits and subject to all applicable c conditions, exclusions and limitatic ons.

We will pay Covered Expenses Incurred for de ntal treatment as a result of Injury to a S Sound Natural Tooth. For dental services, there is often more than one S ervice that can be used to treat a denta l problem. In determining the Ber nefits, different materials and methods of treatment will be considered. The amo unt payable will be limited to the C Covered Expense for the least costly Ser vice, which meets commonly accepted s tstandards of the American Dental Association. The Insured Person and his or her Provider may decide on a m more costly procedure or materia al than We have determined to be satis factory for the treatment of the conditio n. We will pay a Benefit toward the cost of the more expensive procedu re or material, but payment will be limite ed to the Benefits payable for Cov ered Expenses for the least costly Servic ce. We will not pay the excess amount.

When multiple surgeries are performed through t the same incision at the same operative s session, We will pay an amoun t not to exceed the Benefit for the most e xpensive procedure being performed.

ACCID BENTAL DEATH AND SPECIFIC LOSS I BENEFIT

Payme nt for any Accidental Death and Specific L Loss Benefit will be subject to all of the f ollowing conditions:

1. The Loss is caused solely by an Accide nt; and
2. The Loss is not excluded by the terms o f the General Exclusions section of this P Policy; and
3. The Accident must occur while the Insu red Person is participating in a Covered A Activity; and
4. The Loss must occur within 180 days af ter the date on which the Accident occur red.

Sched ule of Losses

We will pay a percentage of the Principal Sum(s) listed in the Schedule of Benefits for th he Benefit as described in the tabl e below, subject to all of the terms and li mitations of the Policy:

Na ture of Loss	Percentage of	f Principal Sum
Li fe		100%
B oth arms or both legs		100%
B oth hands and both feet		100%
O ne arm and one leg		100%
O ne hand and one foot		100%
Ei ther both hands or both feet		100%
S peech and hearing in both ears		100%
Tl ne sight of both eyes		100%
Tl ne sight of one eye and either one hand o r one foot		100%
Ei ther one arm or one leg		75%
Ei ther one hand or one foot		50%
S peech or hearing in both ears		50%
Si ght of one eye		50%
H earing in one ear		25%
B oth the thumb and index finger of one ha nd		25%

If more than one Loss results from any one Acci dent, only one amount, the largest, will b e paid.

Definitions for this Accidental Death and Specific Loss Benefit

Loss: Loss of life or a Specific Loss as shown in the Schedule of Losses (above) which is payable under the Policy's terms and Conditions.

Specific Loss: Means, with regard to:

1. a natural arm or leg, complete severance at or above the elbow or knee joint;
2. a natural hand or foot, complete severance at or above the wrist or ankle joint;
3. a natural thumb and fingers, complete severance at or above the metacarpophalangeal joints;
4. an eye, the complete and irrecoverable loss of sight;
5. speech, the complete and irrecoverable loss of speech;
6. hearing, the complete and irrecoverable loss of hearing of an ear.

EXCLUSIONS

General Exclusions The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced.

We will not pay Benefits for:

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any illegal occupation;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair,

   unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders

We will not pay Benefits for:

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.

3. Expenses Incurred for charges which a re in excess of Reasonable Charges.
4. Expenses Incurred for any condition c overed by any Workers' Compensation A Act, Occupational Disease law or similar law.
5. That part of medical expenses payable t by any automobile insurance Policy with out regard to fault.
6. Expenses Incurred for any treatment ti that is considered to be experimental t by the American Medical Association (AMA) or the American De ntal Association (ADA).
7. Expenses Incurred for the examination , prescription, purchase, or fitting of eye glasses, contact lenses, or hearing aids, unless Injury has causec l impairment of sight or hearing or unles ss repair or replacement of existing eye glasses, contact lenses or h hearing aids is necessary as a result of a covered Injury.
8. Expenses Incurred for new, or repair c r replacement of, dentures, bridges, der tal implants, dental bands or braces or other dental appliances, c rowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Inju ury up to the Dental Maximum shown in t he Schedule of Benefits, if applicable.
9. Expenses Incurred for personal comi dort or convenience items including, bu t not limited to, Hospital telephone charges, television rentals, c r guest meals.
10. Expenses Incurred for or in connection v with Custodial Care, unless otherwise s pecified in the Schedule of Benefits.
11. Expenses Incurred for supervision of a n anesthetist.
12. Expenses Incurred for Durable Medical l Equipment rental in excess of the purch ase price.
13. Expenses Incurred for subsequent rep airs and replacement of prosthetic devic es and orthopedic braces and appliances.

SUBROGAT ION AND RECOVERY RIGHTS

Right oof Recovery

If the a mount of the payment made by Us is n nore than We should have paid under th sis Policy, We may recover the ex ccess from one or more of: (a) The per sson We have paid; (b) The person for whom We have paid; (c) Insura nce companies or any other plan; or (d) other organization. The amount of the payments made includes the rea sonable cash value of any Benefit provic ded in the form of services.

If you or your covered dependent has a claim f or damages from a third party or parties f for any illness or injury for which benefits are payable under this plan, N ationwide Life Insurance Company may have a right of recovery. Our rig ht of recovery shall be limited to the rec covery of any benefits paid for identical covered medical expenses under this plan, but shall not include non-me dical items. Money received for future medical care or pain and sufferi ng may not be recovered. Nationwide Lif e Insurance Company's right of recover y may include compromise settlen ments. You or your attorney must info rm Nationwide Life Insurance Compa my of any legal action or settlen ment agreement at least ten days prior t o settlement or trial. Nationwide Life Ins urance Company will then notify you of the amount it seeks to recover fo r covered benefits paid. Our recovery m ay be reduced by the pro-rata sh are of your attorney's fees and expense s of litigation.

CLAIM PROVISIONS

Notice e of Claim

Writte n Notice of Claim must be given to Us or Our authorized representative within 30 days after a covered Loss starts, or as soon thereafter as is reasonably p ossible. Failure to provide notice within th e required time period will not red uce or invalidate the claim if it was not r easonably possible to give such notice a nd the notice was given as soon a s reasonably possible. Notice should include: (1) the Policy number; (2) the Policyholder's name and addres ss; (3) the Covered Group's name and a ddress; (4) the Insured's name and addr ess; and (5) the Claimant's name and address.

Claim Forms

Claim forms are provided at the time the Policy is issued. Additional Claim forms will be sent to the name and addres ss requested within 10 calendar days afte r a written notice of Claim is received by Our Home Office or one of Our representatives. If not, the Proof of loss requirements can be met without using Our forms. Simply send a written statement indicating the date of the Inju ry as well as the nature and extent of the loss to Our Home Office or to o ne of Our representatives. Proof of loss must be sent within the time limits stated in the next paragraph.

Proof of Loss

Writte n Proof of loss must be sent to Our Hom e Office or to one of Our representative ss within 365 days after: (1) the en d of any period of Inpatient Confineme nt for which Claim is made; or (2) the date of Loss on any other Claim. Failure to furnish the proof of loss with in the time required does not invalidate or reduce a claim if it was not re asonably possible to submit the proof within the required time, if the proof is furnished as soon as reasor nably possible. When We receive notice of Claim that does not contain all nece ssary information or is not

on an aappropriate Claim form, forms for filing I PProof of Loss will be sent to the Claimar ht along with a request for the mi sssing information. We retain the righ t to make subsequent requests for Pr oof of loss if required to accura ltely evaluate and process the Claim. Fa iilure of a Claimant to cooperate with Us s in the administration of a Claim mmay result in the termination of a Claim n. Such cooperation includes, but is nc t limited to, providing any informa ation or documents needed to determine vwhether Benefits are payable or the actu ual amount due.

Payme ent of a Claim

We wil l pay Loss of life Benefits to the Insured s's Beneficiary on file with Us at time of p payment. If more than one Benefi ciary is shown, We will pay the applicat ole percentage specified to each. If no a amount and/or percentage are sp ecified, We will divide the death Bene fits equally among those Beneficiaries living at the time of the Insure d's death. We are not responsible for th ee validity of a Beneficiary designation c mr change. If there are no such B eneficiaries on file, or if none are living a t the time of the Insured's death, We will pay the death Benefits to: (1) the l Insured's estate; or (2) at Our option, tc one or more of the first surviving class of the following classes of succes ssive preference Beneficiaries — the I nsured's surviving: (a) spouse; (b) chi ldren; (c) parents; or (d) brothe rs and sisters, equally.

All oth er Benefits that are not assigned will be paid to the Insured if living; otherwise, at Our option, to those as shown in the paragraph immediately above.

If payr ment is to be made to: (1) an Insured' ss estate; or (2) to an Insured or Bene ficiary who is a minor or otherw ise not competent to give a valid rele ase, We may pay up to $1,000 to the l Insured's parent or legal guardia an, to a person supporting the Insured, o r to any relative by blood or by marriage of either the Insured or his or her Beneficiary whom We consider to be enti tled to the payment.

Subjec t to any written direction of the Insured, por of the legal or natural guardian of the l Insured if the Insured is a minor o r otherwise incompetent to make such a direction, all or a portion of any indemni ities provided by the Policy as a r esult of medical, surgical, dental, Hosp ital or nursing service may, at Our op tion, and unless We are reques ted in writing not later than the time fo r filing Proofs of Loss, be paid directly to the Hospital or person renderi ring such services. If payment is made to the Insured, in no event will pay any amount greater than the amoun t actually paid by the Insured.

It is no t required that a service be furnished by aa specific Provider. Payments made by Us in good faith satisfy Our legal d uuty to the extent of the payment. All pay ments made by Us will be made in United States dollars.

Time o of Payment

After r eceiving proper written Proof of loss, We will pay the periodic Benefits due, n o less often than monthly (unless otherwise stated in the Policy), while t he loss and our liability continue. When Our liability ends, We will pay ar y balance still due after We receive the proper written Proof of loss. Benefits for other losses (including Covere ed Expenses) will be paid within 15 days after We receive proper written Proof of loss, or sooner if required by stat ee law. If We fail to pay the benefit due within this time period, any applicable interest will accrue at the interes t rate required by the state.

Assign nment

We are not bound by an assignment of Benefit ss until We or one of Our representatives receives it in writing from the Ins ured (Insured's parent, if a minor) or his or her legal guardian. We are not respon sible for its validity.

Physic cal Examination and Autopsy

We re serve the rights to have a Physician of Our choice examine the Insured whose condition is the basis of a Claim. This may be done as often as reasona bly necessary while a Claim is pendin g or while We are paying Benefit s. We may also require an autopsy, unle ss forbidden by law. These will be at Our expense.

Free C Choice of Physician

The In sured has a free choice of a Physic ian, Hospital, or other eligible Provid er. The Physician-patient relatior nship will be maintained.

Comm non Accident

If the In sured and his or her Beneficiary die fro m the same Accident without enough evi dence that both died other than at t the same time, the Insured's Benefits w ill be paid as if he or she died last.

Legal Action

No act ion at law or in equity to recover under t he Policy may be brought against Us be fore 60 days after the time written Proof of loss has been sent as required by the Policy. No such action may be brought more than 3 years after t he time written Proof of loss is require d to be sent or after the expiration of the applicable statute of limitati ons, whichever is greater.

Recovery of Overpayment
Payments made by Us which exceed the appropriate amounts payable are recoverable by Us from or among any persons or other entities to whom such payments were made.

GENERAL PROVISIONS

Agency
The Policyholder and any administrator appointed by the Policyholder shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Changes in Policy
The terms of this Policy can be changed only by a written agreement between the Policyholder and Us. Agreement for Us can only be made by Our Executive Vice President or Our Corporate Secretary. Any changes will be made without the consent of, or notice to, any Insured Person. No agent has authority to contract directly with Us for this Policy or to change, alter or amend any of its terms or provisions in any way.

Clerical Error
Any clerical error by the Policyholder or Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and Benefits will be adjusted based on the true facts and the provisions of the Policy.

Conformity with State Laws
The insurance laws of some states require that certain Policy provisions comply with the law of the state for all permanent residents of the state. Any Policy provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements. However, any such provision is modified only for an Insured Person who is a permanent resident of the state at the time Covered Expenses are actually incurred as defined herein.

Entire Contract
The entire contract consists of:
1. this Policy; and
2. any Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy; and
3. the Application of the Policyholder and the Participating Organization, if applicable.

All statements made in the Application, in the absence of fraud, are representations and not warranties. No statement made by the Policyholder or an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to the Policyholder.

Incontestability
Except for material fraudulent misstatements, this Policy will be incontestable, except for non-payment of Premium, after it has been in force for two years.

Individual Certificates
When the law requires it, we will make a Certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which an Insured Person is entitled and to whom the Benefits are payable.

New Entrants
New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

Non-Participating
This Policy is non-participating. This means that it does not share in Our surplus earnings.

Nonduplication of Benefits
If any item of expense is payable under more than one provision of the Policy, payment will be made only under the provision providing the greater Benefit.

Policyholder Required Information
Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

Workers' Compensation Not Affected
The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

NATIO NWIDE LIFE INSURANCE COMPANY
Colum bus, Ohio

Issues this rider to:
Policyh older: BIBB COUNTY SCHOOL D STRICT
Policy I Number: JXS0000027662700
Rider N Number: 1

EXCES SS BENEFITS RIDER

The Ef fective Date of this rider is the Effective I Date of the Policy to which this rider is attached. It applies only with re spect to Accidents that occur on or after t that date. The Policy/Certificate is ame nded as described below. All othe er terms, provisions, limitations and excl usions remain unchanged except as sp ecifically noted within this Benefit f Rider.

We will not pay Benefits under the Basic Accid ent Medical Expense for Covered Expen ses to the extent that they are coll ectible under another Health Care Plan.

We will pay for Covered Expenses denied unde r any other Health Care Plan as being o ut of network or out of the service area, subject to all the terms and limitati ons of the Benefit.

When I Benefits under any other Health Care P lan are covered under this Policy, and c overage under this Policy and the other Health Care Plan are excess, we will pay a pro rata share of the total amo unt of Covered Expenses. In no c ase will the total benefits payable exc eed 100% of the Covered Expenses. C Our pro rata share will be based on the total of Benefits payable under th is Policy in proportion to the total of Ben efits payable by all Health Care P lans for the same Covered Accident or S ickness.

Definit ions for this Excess Benefits Rider

He alth Care Plan: Any arrangement, wh ether purchased or incident to employm ent or membership in an ass ociation or other group, which provides benefits or services for health care, den tal care, disability benefits or r epatriation of remains. A Health Care P lan includes group, ERISA, blanket, fran chise:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangem ents;
4. coverage provided through He alth Maintenance Organizations (HM O), Preferred Provider Organizations (PPO), and other pre payment, group practice and individual p ractice plans;
5. medical benefits provided under au domobile "fault"-type contracts;
6. medical benefits provided by any g overnment plan or coverage or other ben efit law, except:
   a. a state-sponsored Medicaid pla n; or
   b. a plan or law providing benefits c only in excess of any private or non-gov ernmental plan;
7. other valid and collectible medical c r health care benefits or services.

Signed for Nationwide Life Insurance Compa nny

Secretary

President