



Participating Organization Application

I. Application is hereby made for a plan of Group Accident Insurance based on the following statements and representations:

1. Identification of Policyholder:

Name of Policyholder: State of Florida Summer Camp Program
 Department of Management Services
 Address of Policyholder: Washington, D.C.
 Policy Number: PTP N01883409

2. Identification of Participating Organization:

Name of Participating Organization:
 Address of Participating Organization:
 Participating Organization Number:

3. Classification of Eligible Persons:

Class 1 All enrolled day and overnight camp participants of the Participating Organization.

4. Participating Organization Coverage (Choose One Coverage and One Plan):

COVERAGES:

- Day or Overnight Camp: Sponsored Activities Coverage
- Sports Camp: Sponsored Activities Coverage and Sports Coverage

PLANS:

PLAN A:

A. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Principal Sum: \$15,000
 Time Period for Accident: 180 days from the date of the Covered Accident

B. ACCIDENT MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$25,000
 Maximum Benefit Period: 365 days after the date of the Covered Accident
 Time Period for Loss: 180 days from the date of the Covered Accident
 Deductible: \$0
 Dental Services:
 Benefit Maximum: \$1,000
 Maximum per tooth: \$250

PLAN B:

SCOPE OF COVERAGE: Full Excess Benefits

A. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Principal Sum: \$15,000
 Time Period for Accident: 180 days from the date of the Covered Accident

B. ACCIDENT MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$25,000
Maximum Benefit Period: 365 days after the date of the Covered Accident
Time Period for Loss: 180 days from the date of the Covered Accident
Deductible: \$0
Dental Services:
Benefit Maximum: \$1,000
Maximum per tooth: \$250

PLAN C:

A. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Principal Sum: \$15,000
Time Period for Accident: 180 days from the date of the Covered Accident

B. ACCIDENT MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$25,000
Maximum Benefit Period: 365 days after the date of the Covered Accident
Time Period for Loss: 180 days from the date of the Covered Accident
Deductible: \$0
Dental Services:
Benefit Maximum: \$1,000
Maximum per tooth: \$250

C. SICKNESS MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$2,500
Maximum Benefit Period: 365 days after the date of the Covered Sickness
Time Period for Loss: 180 days from the date of the Covered Sickness
Deductible: \$0
Dental Services:
Benefit Maximum: \$1,000
Maximum per tooth: \$250

PLAN D:

SCOPE OF COVERAGE: Full Excess Benefits

A. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Principal Sum: \$15,000
Time Period for Accident: 180 days from the date of the Covered Accident

B. ACCIDENT MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$25,000
Maximum Benefit Period: 365 days after the date of the Covered Accident
Time Period for Loss: 180 days from the date of the Covered Accident
Deductible: \$0
Dental Services:
Benefit Maximum: \$1,000
Maximum per tooth: \$250

C. SICKNESS MEDICAL EXPENSE BENEFITS

Benefit Maximum: \$2,500
Maximum Benefit Period: 365 days after the date of the Covered Sickness
Time Period for Loss: 180 days from the date of the Covered Sickness

Deductible: \$0
 Dental Services:
 Benefit Maximum: \$1,000
 Maximum per tooth: \$250

5. Premiums:

CAMP TYPE	PLAN A per person per day	PLAN B per person per day	PLAN C per person per day	PLAN D per person per day
Day/Overnight	\$0.25	\$0.20	\$0.60	\$0.45
Sports	\$0.45	\$0.30	\$0.95	\$0.70

Such Premiums are due and payable in the following manner: The Applicant agrees to pay the required Premium for these coverages.

6. Participating Organization Effective Date:

7. Participating Organization Termination Date:

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.

 Signed for the Participating Organization

 Title

 Date

 Signed by Licensed Resident Agent
 (Where Required by Law)