

Bartlett City Board of Education Business Meeting

**AUDITORIUM
5705 STAGE ROAD
BARTLETT, TN 38134**

**April 28, 2022
7:00 PM**

- I. INVOCATION
- II. PLEDGE OF ALLEGIANCE
- III. CALL TO ORDER & ROLL CALL
 - A. Official Business of the Day
- IV. SPECIAL PRESENTATIONS
- V. PUBLIC COMMENT
- VI. APPROVAL OF AGENDA
- VII. APPROVAL OF MINUTES OF PREVIOUS MEETINGS
 - A. March 24, 2022 Business Meeting Minutes
- VIII. REPORTS
 - A. Chairman's Report
 - B. Superintendent's Report
 - C. General Counsel's Report
 - D. Tennessee Legislative Network (TLN) Representative Report
 - E. Financial Report
- IX. UNFINISHED BOARD BUSINESS
 - A. Policy 6015: Attendance of Non-Resident Students REVISED
SECOND READING
- X. BOARD ACTION ITEMS
 - A. New Board Business
 - 1. Proposed 2022-2023 BCS Elementary, Middle and High School Fees
 - 2. Bid #FY22009 Oak Elementary Reroof
 - 3. Memorandum of Understanding (MOU) Between Southern College of Optometry (MobilEYES Clinic) and Bartlett City Board of Education
 - 4. Carrier of Student Insurance
 - 5. Sodexo Renewal for BHS
 - 6. RFP K-12 Stem Supplemental Curriculum Lessons Materials, And Services
 - 7. Resolution 9–5 Budget Amendment
 - 8. FY 22-23 Bartlett City Schools Operating Budget
 - 9. 2022 Tenure Recommendations
- XI. ADJOURNMENT

**BARTLETT CITY BOARD OF EDUCATION
BUSINESS MEETING MINUTES**

**AUDITORIUM
5705 STAGE ROAD
BARTLETT, TN 38134**

**March 24, 2022
7:00 PM**

INVOCATION AND PLEDGE OF ALLEGIANCE

Chairman Bryan Woodruff said a prayer. The Board and audience recited the Pledge of Allegiance.

CALL TO ORDER & ROLL CALL

Official Business of the Day

Chairman Woodruff called the meeting to order at 7:00 p.m. The following Board Members were present:

Ms. Erin Berry
Mr. David Cook
Mrs. Shirley Jackson
Mr. Brad Ratliff
Mr. Bryan Woodruff

SPECIAL PRESENTATIONS

Superintendent Stephens introduced Clark Province with Watkins Uiberall. He provided the Board Members a review of the Bartlett City Schools audits.

PUBLIC COMMENT

*Rebecca Guess
5166 Pebble Bridge Lane - Arlington
RE: Pay*

*Laurie Wood, Teacher
6478 Wells Fields Cove
RE: Pre-K Assistant Wages*

APPROVAL OF AGENDA

Chairman Woodruff recommended pulling Board Action Items 4. Bid# FY22009 Oak Elementary Reroof and 5. Resolution 9-5 Budget Amendment. Mr. David Cook made the motion to approve the amended agenda. Ms. Erin Berry seconded the motion. With all ayes, the amended agenda was approved.

APPROVAL OF MINUTES OF PREVIOUS MEETINGS

January 27, 2022 Business Meeting Minutes

The January 27, 2022 Business Meeting Minutes passed with a motion by Mrs. Shirley Jackson and a second by Mr. David Cook.

Ms. Erin Berry: Aye, Mr. David Cook: Aye, Mrs. Shirley Jackson: Aye, Mr. Brad Ratliff: Aye, Mr. Bryan Woodruff: Aye

REPORTS

Chairman's Report

Chairman Woodruff reminded the Board Members that the TSBA Leadership Conference and Annual Convention will be held November 10 - 13th in Nashville. Please let the Board Secretary, Bethany Horn know if you are interested in attending.

Superintendent's Report

Superintendent Dr. David Stephens provided the following updates:

- I returned from the TOSS Legislative Conference today. Governor Lee and Commissioner Schwinn spoke at the conference. The big item is the new funding formula. The bill is still in committee and we are watching it closely.
- The Teacher of the Year Banquet will be held April 7th at 6:30 p.m. at Cedar Hall.
- Bartlett High School Graduation Ceremony will be held at Bellevue Baptist Church on May 9th at 7:00 p.m.
- We are reviewing all hourly employee compensation.
- We are working on next year's budget and will have it ready for our April meeting.
- There will be a Retirement Celebration on March 28th for Joe Anderson, Jimmy Fox, Fay Morrison and Karen Naccarato. They were long-time employees with Shelby County and helped start BCS.

General Counsel's Report

No report.

Tennessee Legislative Network (TLN) Representative Report

TLN Representative Brad Ratliff noted that there are many bills in Nashville to watch at this time.

Financial Report

The February 2021-22 Financial Report was accepted by the Board. It is a non-voting item.

BOARD ACTION ITEMS

New Board Business

Bartlett City Board of Education Meeting Schedule 2022-2023

The Bartlett City Board of Education Meeting Schedule 2022-2023 passed with a motion by Mrs. Shirley Jackson and a second by Mr. David Cook.

Ms. Erin Berry: Aye, Mr. David Cook: Aye, Mrs. Shirley Jackson: Aye, Mr. Brad Ratliff: Aye, Mr. Bryan Woodruff: Aye

Policy 6015: Attendance of Non-Resident Students REVISED FIRST READING

The First Reading of Revised Policy 6015: Attendance of Non-Resident Students passed with a motion by Mr. David Cook and a second by Ms. Erin Berry.

Ms. Erin Berry: Aye, Mr. David Cook: Aye, Mrs. Shirley Jackson: Aye, Mr. Brad Ratliff: Aye, Mr. Bryan Woodruff: Aye

RFP #FY22006 Cleaning Services for Eleven (11) Bartlett City Schools

RFP #FY22006 Cleaning Services for Eleven (11) Bartlett City Schools awarded to ABM Industry Group for Group #1 (Bartlett High School, Altruria Elementary, Elmore Park Middle and Rivercrest Elementary) and ParCou for Group #2 (Oak Elementary, Appling Middle, Bon Lin Elementary, Bon Lin Middle, 9th Grade Academy, Ellendale Elementary, and Bartlett Elementary) passed with a motion by Ms. Erin Berry and a second by Mr. David Cook.

Ms. Erin Berry: Aye, Mr. David Cook: Aye, Mrs. Shirley Jackson: Aye, Mr. Brad Ratliff: Aye, Mr. Bryan Woodruff: Aye

~~**Bid #FY22009 Oak Elementary Reroof**~~ Pulled from Agenda

~~**Resolution 9-5 Budget Amendment**~~ Pulled from Agenda

ADJOURNMENT

The meeting adjourned at 7:30 p.m.

Bryan Woodruff, Chairman

Dr. David A. Stephens, Superintendent

Bartlett City Board of Education		6015
Descriptor Term:	Descriptor Code:	Issue Date:
ATTENDANCE OF NON-RESIDENT STUDENTS	Student Services	02/27/2014
	Rescinds:	Revised: 11/19/2015 05/24/2018

1 Students residing outside the boundaries of the Bartlett City Schools district may attend schools within the
2 district under the following conditions:

- 3 1. They must be approved by the Superintendent.¹
- 4 2. They must provide transportation to and from school. There shall be no obligation for Bartlett City
5 Schools to provide transportation to non-resident students.
- 6 3. They must apply during the Bartlett City Schools open enrollment period in the spring of each year.
7 The District shall communicate the application period to the public annually, and applications
8 received after this period will be considered on a case-by-case basis. Applications made less than
9 two (2) weeks prior to the beginning of the school year or during the school year require approval of
10 the sending district.²
- 11 4. Students residing in Shelby County shall not pay tuition. Out-of-county, non-resident applications
12 shall be considered on a case-by-case basis, and such out-of-county students must pay tuition at a
13 rate established annually by the Board Chief Financial Officer in accordance with T.C.A. §49-6-3003.
14 Such tuition shall be calculated at the maximum amount allowed by law may not exceed per student,
15 per annum, an amount equal to the amount of funds raised and used for school purposes by Bartlett
16 City Schools per student during the preceding school year, minus any funds received from the
17 student's resident system.³ Children of BCS full-time employees shall be exempt from tuition. Out-
18 of-state, non-resident applications shall be considered on a case-by-case basis⁴, and such out-of-
19 state students must pay tuition at the same rate as the average cost per student (state and local
20 funds) in the student's resident district.⁵
- 21 5. They must apply in accordance with applicable state law and Board policy.⁶

22 Non-Resident students will be considered for attendance in Bartlett City Schools based on the following
23 priorities:

- 24 Priority 1: Students of Bartlett City Schools employees, excluding part-time substitute teachers.⁷
- 25 Priority 2: Students currently enrolled in one of the eleven (11) Bartlett schools.
- 26 Priority 3: Students whose siblings currently attend one of the eleven (11) Bartlett schools.
- 27 Priority 4: Students of full time employees of City of Bartlett.
- 28 Priority 5: All other students residing outside the municipal boundaries of Bartlett, Tennessee.

29 The feasibility of approving non-resident applications for admission shall consider, but not be limited to,
30 educational capacity, staffing, and general program offerings. Acceptance for a given year does not
31 guarantee continued acceptance in subsequent years, and applications must be filed annually. Failure to
32 provide and maintain a satisfactory academic, discipline, and attendance record may result in the denial of
33 a non-resident application for admission or a loss of attendance privileges.

¹ T.C.A. §49-6-3104

² T.C.A. §49-6-3104; T.C.A §49-6-3105

³ T.C.A. §49-6-3003(a)

⁴ T.C.A. §49-6-3108

⁵ T.C.A. §49-6-403(f)

⁶ T.C.A. §49-6-3102(e)

⁷ T.C.A. §49-6-3113

2022-2023 Student Accident Coverage

Serviced by: **K&K Insurance Group, Inc.** Phone: 855-742-3135

**Remember to visit our website for faster enrollment: www.studentinsurance-kk.com
Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.**

ACCIDENT ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of \$25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

SCHEDULE OF BENEFITS: *Maximum Benefits Paid As Specified Below.*

Compare and Choose	Low Option Accident Only	High Option Accident Only
Maximum Benefit:	\$25,000 (For Each Injury)	\$25,000 (For Each Injury)
Deductible:	\$0	\$0
Inpatient Hospital Services		
Room & Board Expenses:	Up to \$150 per day/ Semi-private room rate	80% of Usual and Customary Charges/ Semi-private room rate
Miscellaneous Expenses:	\$600 maximum per day	\$1,200 maximum per day
Physician's Visits: <i>(Limited to one visit per day)</i>	\$40 first day/\$25 each subsequent day	\$60 first day/\$40 each subsequent day
Ambulatory Medical Center		
Emergency Room Treatment: <i>(Treatment must be rendered within 72 hours from the time of the injury)</i>	\$150 maximum	\$300 maximum
Surgery <i>(*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.)</i>	\$1,000 maximum	\$1,200 maximum
Assistant Surgeon	100% of Usual and Customary Charges <i>(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</i>	100% of Usual and Customary Charges <i>(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</i>
Anesthesia and its Administration	100% of Usual and Customary Charges <i>(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)</i>	100% of Usual and Customary Charges <i>(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)</i>
Outpatient		
Outpatient Physician Visits: <i>(Limited to one visit per day)</i>	\$40 first day/\$25 each subsequent day	\$60 first day/\$40 each subsequent day
Outpatient X-ray:	\$200 maximum	\$600 maximum
Outpatient Diagnostic Imaging Services:	\$300 maximum	\$600 maximum
Outpatient Laboratory:	\$50 maximum	\$300 maximum
Outpatient Physiotherapy: <i>(Limited to one visit per day. Includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)</i>	\$30 first day/\$20 each subsequent day/ 5 days maximum	\$60 first day/\$40 each subsequent day/ 5 days maximum
Ambulance Services: <i>(Air and Ground)</i>	\$300 maximum	\$800 maximum
Medical Equipment Rental: <i>(Includes Orthopedic devices)</i>	\$75 maximum	\$140 maximum
Dental Services:	\$10,000 maximum per policy	\$10,000 maximum per policy term
Prescription Drugs:	\$75 maximum	\$200 maximum
Consultant:	\$200 maximum	\$400 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids:	100% of Usual and Customary Charges	100% of Usual and Customary Charges

THIS IS A BLANKET ACCIDENT ONLY POLICY.

U.S. Insurance coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909, et al. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

Choose Your Coverage Plan: *One-Time Payment For Accident Coverage*

PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW

Coverage Effective Date: A person's coverage takes effect at the later of the date his or her completed student accident enrollment form and premium is received by the company or the effective date of the policy issued to his or her school or school district.

Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be an eligible person per the definition below. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

	Low Option	High Option
24-Hour Accident Around-the-clock. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football.	\$112.00	\$165.00
24-Hour Accident (Summer Only Coverage) Summer begins on the first day after the school year ends. Summer ends the first day of the next school year.	\$39.00	\$51.00
At-School Accident During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes. School Sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.	\$30.00	\$38.00
High School Football (Full Year) Play or practice of regularly scheduled football.	\$176.00	\$293.00
High School Football (Spring Only Rates) For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.	\$76.00	\$124.00
High School Football and At-School Accident (Covers all athletics)	\$206.00	\$331.00
High School Football and 24-Hour Accident (Covers all athletics)	\$288.00	\$458.00

About Your Coverage

1. **ELIGIBLE PERSONS:** students of the policyholder who enroll and make the required premium contribution for the coverage selected are Eligible Persons under the Policy. Depending on the coverage selected, coverage may continue after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy is on file with the school district and is a non-renewable policy. The student coverage selected is non-renewable and requires the student to re-enroll each school year.
3. This is a limited benefit policy.
4. **COVERAGE EFFECTIVE DATE:** Insurance becomes effective for a student who enrolls and makes the required premium contribution on the latest of the following dates:
 - a. the Policy Effective Date;
 - b. the date the Company receives student's completed enrollment form and the required premium payment.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.
5. **COVERAGE TERMINATION DATE:** Coverage ends on the earlier of the date: he or she is no longer an Eligible Person, the end of the 1 year coverage term or the date the School's policy ends. All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim for a Covered Accident that occurs before the termination date.
6. **LATE ENROLLMENT:** Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.
7. **CANCELLATION:** Your coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company.

Enroll online at:

www.StudentInsurance-kk.com

or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to Axis Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Mail completed enrollment form with payment back to:

**K&K Insurance Group,
P.O. Box 2338
Fort Wayne, IN 46801-2338**
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

Administered by:

K&K Insurance Group, P.O. Box 2338,
Fort Wayne, IN 46801-2338

 Cut out card and retain for your records

STUDENT INSURANCE CARD

Student's Name _____

If premium has been paid, the student whose name appears above has been insured under a Policy issued to:

School District: _____

Accident Only Coverage: 24-HOUR 24-HOUR (Summer Only Coverage)

AT-SCHOOL FOOTBALL FOOTBALL (Spring Only) EXTENDED DENTAL

Paid by Check # _____ Amount Paid: _____ Date Paid: _____

Policy # _____

Underwritten by: AXIS Insurance Company
Claims Questions: K&K Insurance Group, Inc.
1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

- intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
- commission or attempt to commit a felony or an assault;
- commission of or active participation in a riot or insurrection;
- declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
- flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
- travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
- voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- injuries compensable under Workers' Compensation law or any similar law;
- operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
- the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
- an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
- aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
- 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;
- medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
- benefits will not be paid for services or treatment rendered by any person who is:
 - employed or retained by the Policyholder;
 - living in the Insured Person's household;
 - an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
 - the Insured Person.

EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

- cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
- any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
- examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
- treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
- services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
- repair or replacement of existing artificial limbs, eyes and larynx;

- treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits.

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENT ONLY DEFINITIONS:

Covered Injury means Accidental bodily injury:

- which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force;
- which results directly and independently from all other causes from a Covered Accident; and
- which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident or Accidental: means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Covered Expenses: means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Medically Necessary: means medical services that:

- are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
- meets generally accepted standards of medical practice; and
- are ordered by a Physician and performed under His care, supervision or order.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Covered Loss must occur within 365 days of the Covered Accident. Not more than the Aggregate Limit of \$500,000 will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage. This Aggregate Limit is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit.

COVERED LOSS	BENEFIT AMOUNT
Loss of Life	\$10,000
Loss of Two or More Hands or Feet	\$10,000
Loss of Sight of Both Eyes	\$10,000
Loss of Speech and Hearing (in Both Ears)	\$10,000
Loss of One Hand or Foot and Sight in One Eye	\$10,000
Loss of One Hand or Foot	\$5,000
Loss of Sight in One Eye	\$5,000
Loss of Speech	\$5,000
Loss of Hearing (in Both Ears)	\$5,000
Loss of Hearing in One Ear	\$2,500
Loss of Thumb and Index Finger of the same Hand	\$2,500
Exposure and Disappearance	Included

IMPORTANT NOTICE - FRAUD WARNING

- **In General, and specifically for residents of Arkansas, Illinois, 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 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 or 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 or 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.
- **For residents of Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of Virginia:** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.



**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
email:kk.PAClaims@kandkinsurance.com
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: _____
2. Date of Birth: _____ SS# _____ Sex: Male Female
3. Student's grade in school: _____ Email address: _____
4. Home Address Street: _____
City: _____ State: _____ Zip: _____
Parent(s)/Guardian(s) Home Phone: _____
5. Date of Accident: _____ Time of Accident: _____ AM 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):

<input type="radio"/> Pre-Kindergarten	<input type="radio"/> Elementary School	<input type="radio"/> Middle School
<input type="radio"/> High School	<input type="radio"/> Cafeteria	<input type="radio"/> Classroom Activities
<input type="radio"/> Interscholastic Sports	<input type="radio"/> Intramural Sports, <i>name of sport, if applicable:</i> _____	<input type="radio"/> Other Activity (specify) _____
<input type="radio"/> Club Sports	<input type="radio"/> Physical Education Class	<input type="radio"/> During Travel To or From the Event
<input type="radio"/> During Practice	<input type="radio"/> During Play	

Nature of Your Participation:

<input type="radio"/> Student	<input type="radio"/> Volunteer	<input type="radio"/> Student/Manager
<input type="radio"/> Athletic Participant	<input type="radio"/> Cheerleader	<input type="radio"/> Band Member
<input type="radio"/> Other (specify) _____		
7. Transfer Student? Yes No
If yes, please identify the former school name: _____
8. Name, address and phone number of physician who first treated you: _____

9. Have you had a similar injury in the past? Yes No

If yes, describe and give dates: _____

10. Name, address and phone number of physician who treated you for previous injury: _____

11. Are you covered by any other medical expense benefits plan? Yes No

If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date _____ Parent/Guardian Signature _____

SECTION II

(TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Student's Name Last: _____ First: _____ MI: _____

2. Date of Accident _____

3. Activity _____

4. Nature of Injury _____

5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT _____

6. Name of participating SCHOOL _____

7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNATURE OF SCHOOL OFFICIAL: _____

PRINTED NAME/TITLE: _____

PHONE: _____ FAX: _____

EMAIL: _____ DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files forms 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.

Date _____ Policyholder (School Official) Signature _____

IMPORTANT NOTICE

• **In General, and specifically for residents of Arkansas, Illinois, 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 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 or 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 or 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.

• **For residents of Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

• **For residents of Virginia:** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

[AXIS_FRAUD 0220]

Dear Participant: If you have an appointment with a doctor as a result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates.



HYGIEA

INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT/GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.



OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT Yes No
 EMANCIPATED STUDENT: Yes No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: Yes No
 NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IS FATHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IS MOTHER LEGALLY RESPONSIBLE? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No SELF-EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have group medical insurance coverage through your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is it: <input type="checkbox"/> Individual <input type="checkbox"/> Family	If Yes, is it: <input type="checkbox"/> Individual <input type="checkbox"/> Family
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 COMPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGE <input type="checkbox"/> OTHER (describe) _____	TYPE OF PLAN: <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="checkbox"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGES <input type="checkbox"/> 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: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL, INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZED ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

AXIS INSURANCE COMPANY

(A Stock Company)

(Herein called the Company)

Administrative Office:
1 University Square Drive, Suite 200
Princeton, NJ 08540

Home Office:
111 South Wacker Drive, Suite 3500
Chicago, IL 60606

BLANKET ACCIDENT POLICY/CERTIFICATE AMENDMENT

POLICY AMENDMENT NO. 0000

POLICY RENEWAL

POLICYHOLDER: BARTLETT CITY SCHOOLS

DOING BUSINESS AS:

POLICY NUMBER: KAMV0000018033601

POLICY EFFECTIVE DATE: 07/01/22

POLICY ANNIVERSARY: 07/01

STATE OF ISSUE: TN

This Amendment is attached to and made part of the Policy effective 07/01/22 at 12:01 AM, Standard Time. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

It is hereby understood and agreed the Policy is renewed for a period of one year, commencing 07/01/22 and ending 08/31/23 .

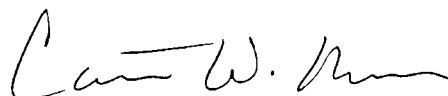
Renewal Premium: AS REPORTED

This Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Amendment.

The President and Secretary of AXIS Insurance Company witness this Amendment:



Secretary



President



Underwritten by:
AXIS Insurance Company
 Serviced by:
K&K Insurance Group, Inc.

MANDATORY & VOLUNTARY BLANKET MASTER INSURANCE APPLICATION

Coverage not available in the following states: AR, MD, NH, NY, WA

Application is hereby made for a plan of BLANKET ACCIDENT INSURANCE based on the following statements and representations:

Policyholder: Name of School/District _____
 Requested Effective Date: _____ Requested Termination Date (one year from the Requested Effective Date): _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Mailing Address (if different): _____
 Contact Name: _____ Title: _____
 Phone: _____ Fax: _____
 Email: _____

Mandatory Accident Coverage (Coverage selected by school/district)

	<i>Product Option</i>	<i>Grades</i>	<i>Total # of Insured</i>	<i>Rate</i>	<i>Premium</i>
At-School Including Athletics & Activities					
At-School Excluding Athletics & Activities					
Athletics & Activities					
Field Trip					
School Band					
JROTC					
Other (Please Specify)					
Other (Please Specify)					
Other (Please Specify)					
Total Mandatory Premium Due:					_____

Voluntary Accident Coverage

Estimated annual school enrollment (total number of students): _____
 Grades (mark one): PK-12 Elementary School Middle School High School
 Effective Date: _____

The terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. The terms of the policy when issued will govern. It is agreed the insurance applied for will not become effective unless a) this application is received and approved by AXIS Insurance Company based on current rules and requirements; b) the policy is accepted by the applicant; and c) the required premium is paid when due.

The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.

POLICYHOLDER SIGNATURE

 Authorized Signature of Applicant

 Printed or typed name of Applicant's Authorized Representative

 Date

LICENSED BROKER/AGENT SIGNATURE

 Licensed Broker/Agent

 License Number

 Date

IMPORTANT NOTICE - FRAUD WARNING

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- **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.
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- **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.
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- **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 or 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.
- **For residents of Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of Virginia:** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

Bartlett City Schools
2022 Tenure Candidates

1. Andrea Beasley- Rivercrest Elementary
2. Toni Berryhill- Appling Middle School
3. Shirah Beyer- Elmore Park Middle School
4. Amber Combs- Altruria Elementary
5. Carlyn Cosmini- Bartlett Elementary
6. Bobbie Currey- Elmore Park Middle School
7. Sara Duffy- Bon Lin Middle School
8. William Edwards- Rivercrest Elementary
9. Wesley Hansen- Elmore Park Middle School
10. Susanna House- Ellendale Elementary
11. Chanelle Houston- Bon Lin Middle School
12. Amy Milzarek- Altruria Elementary
13. Misty Nichols- Bon Lin Middle School
14. Amber Roland- Rivercrest Elementary
15. Marcy Ross- Bartlett High School
16. Trevor Rundell- Bartlett High School
17. Laura Shores- Bon Lin Elementary
18. Katherine Sinclair- Bartlett High School
19. Elizabeth Smith- Bon Lin Middle School
20. Kimberly Zachar- Rivercrest Elementary