

POLICYHOLDER NAME & ADDRESS CUMBERLAND PUBLIC SCHOOLS 2602 MENDON ROAD	CITY, STATE, ZIP CUMBERLAND, RI 02864	COUNTY
TELEPHONE NUMBER 401 658-1600	GRADES INCLUDED PK - 12	ESTIMATED # OF STUDENTS 5,800

**VOLUNTARY STUDENT ACCIDENT COVERAGE**  
 ACCIDENT MEDICAL EXPENSE MAXIMUM UP TO \$1,000,000

PLAN II (PLAN I NOT AVAILABLE)	EFFECTIVE DATE <u>08/05/2013</u>	SCHOOL TIME RATE <u>\$7.50</u>
<input checked="" type="checkbox"/> FULL EXCESS <input type="checkbox"/> INCLUDES SPORTS OTHER THAN SR HS FOOTBALL	EXPIRATION DATE <u>09/01/2014</u>	24-HOUR RATE <u>\$45.00</u>
<input type="checkbox"/> PRIMARY <input checked="" type="checkbox"/> INCLUDES SPORTS	MAXIMUM BENEFIT PERIOD - 1 YEAR	EXTENDED DENTAL RATE <u>\$8.00</u>
<input type="checkbox"/> EXCLUDES SPORTS		SR HIGH FOOTBALL <u>\$9.50</u> PER PLAYER

**COMPULSORY STUDENT ACCIDENT COVERAGE (100% PARTICIPATION-PREMIUM PAID BY THE SCHOOL)**  
 ACCIDENT MEDICAL EXPENSE MAXIMUM UP TO \$1,000,000

PLAN _____	EFFECTIVE DATE _____	SCHOOL TIME RATE _____
<input type="checkbox"/> FULL EXCESS <input type="checkbox"/> INCLUDES SPORTS OTHER THAN HS FOOTBALL	EXPIRATION DATE _____	24-HOUR RATE _____
<input type="checkbox"/> INCLUDES HS SPORTS AND FOOTBALL	MAXIMUM BENEFIT PERIOD	TOTAL PREMIUM \$ _____
	<input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS	

**INTERSCHOLASTIC SPORTS OR FOOTBALL COVERAGE**  
 ACCIDENT MEDICAL EXPENSE MAXIMUM UP TO  \$1,000,000  \$25,000

PLAN _____	<input type="checkbox"/> HIGH SCHOOL FOOTBALL	EFFECTIVE DATE _____	
<input type="checkbox"/> FULL EXCESS <input type="checkbox"/> HIGH SCHOOL SPORTS	<input type="checkbox"/> BAND, CHEERLEADER, MAJORETTES	EXPIRATION DATE _____	
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> EXPANDED SPORTS MEDICAL COVERAGE	MAXIMUM BENEFIT PERIOD	TOTAL PREMIUM \$ _____
		<input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS	

**SPECIAL NOTES:**  
 INCLUDES EXPANDED SPORTS MEDICAL RIDER

**FRAUD WARNING:** 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.

WE UNDERSTAND THAT INSURANCE WILL BE IN FORCE ONLY IF THE REQUIRED PREMIUM IS RECEIVED BY THE COMPANY BY THE REQUEST EFFECTIVE DATE.

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_

LICENCED AGENT		REGIONAL ADMINISTRATOR	
NAME	<u>LEFEBVRE INSURANCE, LLC</u>	NAME	<u>LEFEBVRE INSURANCE, LLC</u>
ADDRESS	<u>850 FRANKLIN STREET</u>	ADDRESS	<u>850 FRANKLIN STREET</u>
CITY/ STATE/ ZIP	<u>WRENTHAM, MA 02093</u>	CITY/ STATE/ ZIP	<u>WRENTHAM, MA 02093</u>
SIGNATURE LICENCED AGENT	_____	SIGNATURE LICENCED AGENT	_____
TAX ID #	_____	TAX ID #	_____