

2026-2027
NORTH AMERICAN DIVISION OF SEVENTH-DAY ADVENTIST
K-12 ACCIDENT INSURANCE COVERAGE REQUEST FORM

Name of School or School District _____

_____ Street Address _____ City _____ State _____ Zip Code _____

_____ Phone _____ Fax _____ Email Address _____

ELIGIBILITY:

Class 1 - All enrolled students (grades PK-12, includes enrolled and registered early childhood infants to school age), including the graduating class trip, religious services or instructions and all interscholastic student athletes excluding senior high football are covered under the Policyholder program for whom premium has been paid.

Class 2 - All enrolled boarding students (grades PK-12) excluding senior high football are covered under the Policyholder program for whom premium has been paid.

BASE PLAN OPTIONS:

Please make selections below indicating the Desired Plan of Coverage.

	Class 1:	Corridor Deductible	1a: Preschool & Kindergarten	*1b: Day Students Grades 1-8	1c: Students Grades 9-12
	Full Excess	\$0.00	\$5.85	\$11.90	\$36.80
	Full Excess	\$100.00	\$4.00	\$9.15	\$27.65
	\$500 Primary Excess	\$0.00	\$8.75	\$16.85	\$49.05

	Class 2:	Corridor Deductible	Boarding Students
	Full Excess	\$0.00	\$114.95
	Full Excess	\$100.00	\$84.55
	\$500 Primary Excess	\$0.00	\$194.00

*If a school has 9th & 10th grade students and no 11th & 12th grade students, use rates for Grades 1-8 for the 9th & 10th grade students.

CAT PLAN OPTIONS:

Please make one of the boxes below indicating the Desired Plan of Coverage.

☐	Option 1: Medical Only	\$2.05
☐	Option 2: CAT Cash	\$2.90

\$ _____ X _____ = \$ _____
Base Class 1a: Rate Per Student # of Students

\$ _____ X _____ = \$ _____
Base Class 1b: Rate Per Student # of Students

\$ _____ X _____ = \$ _____
Base Class 1c: Rate Per Student # of Students

\$ _____ X _____ = \$ _____
Base Class 2: Rate Per Student # of Students

\$ _____ X _____ = \$ _____
CAT : Rate Per Student# of Students # of Students

TOTAL PREMIUM DUE (for the benefits shown above) \$ _____

(The Premium Due is fully earned and nonrefundable on the effective date of coverage)

Underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

Make premium check payable to Academic HealthPlans and mail payment along with this completed form to the following office:

**Academic HealthPlans
16201 W. 95th Street, Suite 210
Lenexa, KS 66219
913-815-1300 direct
Attn: Stephanie Williams**

***Enrollment Period - 6/1/26-10/30/26. Enrollment forms will not be accepted after 10/30/26.**

Term of Coverage

It is understood that the effective date of coverage under this program will be August 1, or the date this form and the premium are received and accepted by the Company, whichever is later. Coverage for this term will end on August 1.

By _____ Date _____
Signature of Contracting Official

Licensed Agent's Signature License Number Date

