AMERICAN INCOME LIFE
insurance company

SPECIAL RISK
DIVISION

Trust the Leader

American Income Life has been insuring 4-Hers across the country since 1952. We currently serve thousands of 4-H clubs in over 2200 counties nationwide. Experience and knowledge you can trust at work for the children entrusted to your care. We have first hand knowledge of the types of claims and situations that arise during 4-H and Extension activities. Take advantage of our years of experience and insure your programs with a Division that was founded with 4-H in mind.

Promoting 4-H

Through our sponsorships and donations to 4-H programs nationally, we convey our dedication to promoting 4-H and Extension and their ideals.

Safety First

ALL our programs offer PRIMARY, NO DEDUCTIBLE coverage for ALL registered 4-Hers and leaders. We encourage you to make sure your programs are age-appropriate and in compliance with your state's guidelines.

Worth Noting

4-H Club Leaders

We have an excellent Option of annual coverage available on an individual club or county-wide basis. If you use our Special Activities brochures several times a year, it might be advantageous for you to have the annual club coverage. CONTACT US FOR DETAILS.

Apply Online Now at
www.americanincomelife.com

"Serving Those Who Serve Others"
is not just our motto–it's our business!!

READ THESE INSTRUCTIONS CAREFULLY!

HOW TO APPLY FOR COVERAGE

1. To apply, complete the APPLICATION FORM, giving approximate number to be insured, the beginning date and the number of days for which you wish coverage. Coverage is from midnight to midnight. Any over-night activity requires two day coverage
2. Be sure to check Option of coverage desired. If no Option is checked, coverage is automatically bound under Option A.
3. Be sure application bears a postmark of AT LEAST ONE DAY PRIOR TO THE EFFECTIVE date, or request coverage online at: www.americanincomelife.com; or fax 317-849-2793 (24 hours).
4. The company requires notification of date changes.
5. NO ADVANCE PREMIUM.
   At time of remittance, a minimum of $8.00 is required.
6. If, for any reason, duplicate coverage for any event is applied for, the claims will be paid under the policy providing the greater benefits.

HOW TO FILE A CLAIM

1. Written notice of claim must be given to the company within twenty days of commencement of any loss covered by this policy, or as soon as is reasonably possible.
2. In case of injury or illness to any insured person, see that they are given proper medical attention. Complete a claim report with the following information and mail or fax to the Company as soon as possible:
   a. Name and date of birth of the claimant.
   b. Date of the injury/illness.
   c. How the injury/illness was sustained.
   d. Complete medical diagnosis by the attending physician.
   e. Serial number of application under which person was covered.
3. Statements for services rendered by doctor, hospital or nurse, are necessary in all instances.
4. Claim reports must be signed by group leader.

Special Activities Coverage for Accident or Illness

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SPECIAL RISK
DIVISION

For
Youth, Volunteer Leaders, and Adults

Participating in
Adult Supervised Activities

Sponsored by
the Cooperative Extension Service

At
Camps, Conferences, Fairs, Tours,
and Meetings Including Travel Time

Issued Under
MASTER POLICY NO. 717
on file with the Director of Extension Service
PURDUE UNIVERSITY, LAFAYETTE, INDIANA
as trustee for all Members and Adult Leaders
in the United States and Its Possesions

All Options provide primary coverage with no deductible.

Table of Benefits	Option A 20¢ Per day per person	Option B 25¢ Per day per person	Option C 30¢ Per day per person
For expense incurred within 52 weeks of the date of Accident for Medical and Surgical Treatment, X-Ray Examinations, Hospital Confinement and Ambulance Expense, up to a maximum of...	$2,500	$3,000	$5,000
Dental Services incurred within 52 weeks of the Accident, Involving Sound Natural Teeth, up to a maximum of...	$400	$500	$1,000
Medical and Hospital Expense for Illness having its inception on the day or days this policy is in force, up to a maximum of...	None	$1,000	$1,500
For Medical Expenses from these specified diseases: Poliomyelitis, Diphtheria, Scarlet Fever, Smallpox, Tetanus, Cerebrospinal Meningitis, Typhoid Fever, Leukemia, or Primary Encephalitis, up to a maximum of...	None	$3,500	$5,000
For losses within 100 days of the accident which result in the loss of life...	$2,500	$3,000	$5,000
For losses within 100 days of the accident which cause loss of both hands, or both feet, or the total sight of both eyes or one hand and one foot...	$7,500	$7,500	$10,000
For losses within 100 days of the accident which cause the loss of one hand or one foot or sight of one eye...	$2,500	$2,500	$5,000

This policy does not cover the following:

- Eyeglass Replacement
- Suicide
- Aviation Accidents
- Pre-Existing Conditions
- Hernia in any form
- Any loss caused by or resulting from pregnancy
- Staff Employees covered under Worker's Compensation

Transportation Coverage

This insurance covers group travel to and from the sponsored activity. It is required that such group be accompanied by an Adult Leader. The enroute day or part of a day must be included in the approximate number of days for which insurance is applied.

Complete for your records.

Application # _____

Activity _____

Option _____ # Days _____

Date _____

Paid $ _____ Check # _____

Mailed to Company _____

AMERICAN INCOME LIFE
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SPECIAL RISK DIVISION

American Income Life Insurance Co.
PO Box 50158
Indianapolis, IN 46250
317-849-5545 or 317-849-2793
www.americanincomelife.com

Send AFTER Your Return

REMITTANCE FORM

Mail with payment after activity.

SEND TO: Date: _____

American Income Life Insurance Co.
PO Box 50158
Indianapolis, IN 46250

I Enclose the sum of $_____

$8.00 minimum required per activity.

Our group was insured under:

	# People	X	# Days	X Rate	=	Payment
☐ Opt. A	_____	X	_____	X .20	=	_____
☐ Opt. B	_____	X	_____	X .25	=	_____
☐ Opt. C	_____	X	_____	X .30	=	_____

The effective date was _____ (give date)

_____
Name of Group

_____
What was the Activity

I certify that the above figures are correct and agree with the registration list for our activity.

Signed _____

_____
Title

_____
Address

_____
City State Zip

_____
County Phone

The SERIAL NUMBER is Very IMPORTANT!

The Remittance and the Application forms bear the SAME serial number. Send this Remittance with your premium payment.

Rev 10/11

Remittance Form Serial NO. № 123711

Send BEFORE You Leave

APPLICATION FORM

This application MUST bear a postmark at least one day prior to the effective date OR submit at least one day prior by fax at 317-849-2793 or apply online at www.americanincomelife.com

SEND TO: Date: _____

American Income Life Insurance Co.
PO Box 50158
Indianapolis, IN 46250

Please cover our group under: (check Option) Master Group Policy No. 717

IF NO OPTION CHECKED COVERAGE BOUND UNDER OPTION A.

☐ Option A at 20¢ per day per person

☐ Option B at 25¢ per day per person

☐ Option C at 30¢ per day per person

Date insurance is to be in force _____ (give date)

Number of persons to be insured _____ (approximate #)

Number of days to be insured _____
(COVERAGE FOR ANY DAY ENDS AT MIDNIGHT)
(If Non-Consecutive dates please list all days to be insured)

The leader agrees to make an accurate report to the Company and remit the total premium according to the Option requested for each person participating.

_____
Name of Group

_____
What is the Activity

Leader _____

_____
Address

_____
City State Zip

_____
E Mail

_____
County Phone

We'll send you more APPLICATION FORMS!

Send _____ Application Forms

Rev 10/11

Application Form Serial NO. № 123711