Student Travel Accident Program
Coverage Summary

Insurance Company Information:

Insurance Company	Wellfleet Insurance Company
A.M. Best Rating	A++
Standard & Poor's Rating	N/A
State Covered Status	Admitted
Policy/Coverage Term	December 31, 2024 – December 31, 2025
Policy #	MP0000851787

How to Report a Claim:

Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after the occurrence or commencement of a Covered Loss, or as soon thereafter as is reasonably possible.

Wellfleet Special Risk:

specialriskCS@wellfleetinsurance.com
877-657-5039 Voice

413-733-4612 Fax

How to Request a Certificate of Insurance:

1. Request a Certificate of Insurance within the Members Only section of www.CSURMA.org … **OR**
2. Email an Alliant staff member directly:

La Shaunda Wallace (primary)
LaShaunda.Wallace@alliant.com
415-403-1489

Tevea Him (secondary)
thim@alliant.com
415-403-1416

Covered Parties:

All enrolled California State University (CSU) students, including students enrolled only in extended education programs, of the California State University

Covered Activities:

1. School Coverage: Policyholder Supervised and Sponsored Activities while away from the Policyholder's campus which (1) are part of a course requirement; or (2) are sponsored by a university auxiliary organization, including but not limited to associated student associations, or other recognized student organization or club, including Policyholder supervised and sponsored field trips.
2. On-campus Policyholder activities are not included under Covered Activities.
3. Covered travel includes travel to and from intercollegiate athletic events away from campus but does not include participation in such events or practices, nor does it include travel for participants in such events or practices.

This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such policy(ies). Moreover, the information contained in this document reflects coverage as of the effective date(s) this document was created and does not include subsequent changes. This document is not an insurance policy and does not amend, alter, or extend the coverage afforded by the listed policy(ies) and the policy(ies) listed are subject to all the terms, exclusions, and conditions of such policy(ies).

4. Overnight Supervised and Sponsored Activities with duration of more than 14 days and related travel are not covered unless specifically agreed to in writing by Us.

Coverage Territory: United States of America

Coverage Limits:

1. Accident Medical Expenses – Total Maximum Benefit Amount $50,000
2. Accidental Death $10,000
3. Accidental Dismemberment $10,000
4. Aggregate Limit of Liability $500,000

Medical Expense Deductible:

1. Each covered accident and includes Covered Expense paid under another Health Care Plan $0
2. From the date of the Covered Accident ..... One-Year
3. After a Covered Accident ..... 180 days

Major Exclusions: *(including but not limited to):*

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane.
2. Commission or attempt to commit a felony or an assault.
3. Commission of or active participation in a riot or insurrection.
4. Bungee jumping; parachuting; skydiving; parasailing; hang-gliding.
5. Declared or undeclared war or act of war.
6. Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline.
7. Travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle.
8. Participation in any motorized race or contest of speed.
9. An accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program.
10. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
11. Travel or activity outside the United States.
12. The Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred.
13. 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.
14. Injuries compensable under Workers' Compensation law or any similar law.

We will not pay benefits for:

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15. Services or treatment rendered by a Physician, Nurse or any other person who is:

    a. Employed or retained by the Policyholder.

    b. Living in the Covered Person's household.

    c. Who is a parent, sibling, spouse or child of the Covered Person.

16. Any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.

17. A Covered Person's Covered Loss if:

    a. He was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and

    b. He was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

Questions:

Stacey Weeks
415-403-1448
sweeks@alliant.com

Van Rin
415-403-1408
vrin@alliant.com

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PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskCS@wellfleetinsurance.com
fax: (413) 733-4612

PLEASE FULLY COMPLETE THIS FORM

ATTACH ITEMIZED BILLS

MAIL ALL INFORMATION TO THE ABOVE ADDRESS

PART I – POLICYHOLDER'S REPORT

Participating Group Number:	Policyholder Number:	Policyholder Name:	Event, Activity or Sport
SR543099	MP0000851787	The Trustees of California State University	

Claimant's Name (Injured Person)	Social Security Number	Gender	Date of Birth	E-Mail Address
		☐ M ☐ F		

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a:
		☐ Particpant ☐ Staff Member ☐ Other

Dental Claim	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident:
		☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured and left or right side– e.g. broken arm, sprained ankle, etc.)

Did Injury Result in Death? ☐ Yes ☐ No

Describe How Accident Occurred – Give All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? ☐ Yes ☐ No

B. On activity premises? ☐ Yes ☐ No

C. While traveling directly and uninterruptedly to or from the event? ☐ Yes ☐ No

D. During intercollegiate/scholastic athletic practice or competition? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge and belief, that the person named above is insured by the policy, and that his or her insurance was in effect on the date the accident occurred.

Signature of Plan Sponsor	Name, Title and Telephone Number of Plan Sponsor	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐ **Yes** ☐ **No**

If yes name of insurance company: _____ **Policy #:** _____

Other Insurance Carrier ID# _____ **Other Insurance Carrier Telephone#** _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ **Yes** ☐ **No** **If yes, please explain:** _____

IF OTHER INSURI IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

I agree that should it be determined at a later date there is another insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

SIGNATURE _____ **DATE** _____

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or informat concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records or all such records in their entirety to Wellfleet Group, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

I certify that the above information is correct to the best of my knowledge and belief. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ **DATE** _____

FRAUD STATEMENTS

Important Notice

- ***In General, and specifically for residents of Arkansas, 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, Virginia 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 and 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 and 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.