Y.O.U. ACCIDENT INSURANCE

An accident insurance policy is maintained for all Y.O.U. members, coordinators, chaperones and assistants. The coverage is paid for by the Y.O.U. members. Following is a brief description of the insurance provided:

* Accident Medical Expense	$10,000
* Accidental Dismemberment	10,000
* Accidental Death	2,500
* Dental (maximum benefit)	250
* Deductible	25

Please note that the coverage is for **accidents only.** This insurance does not include any coverage for sickness nor is it intended to replace any existing major medical or catastrophic insurance presently in force. It is only intended to provide financial aid (subject to the above limits) in the unfortunate event that an accident occurs.

This insurance affords coverage only while participating in an approved and supervised Y.O.U. activity, either on an international, national or local basis. It includes accidents which occur while traveling directly to or from such activities (although, if involved in an auto accident, auto insurance should be treated as primary).

Following are those items which are excluded from coverage (quoted from the policy):

This policy does not cover loss resulting from:

a) intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane;
b) injury sustained while:
   i) in or on:
   ii) boarding or alighting from:
   iii) being struck or run down by:
      any aircraft in motion, except as an airline passenger on an aircraft:
         i) operated by a passenger airline;
         ii) on a regularly scheduled trip over its established route;
c) war or act of war, whether declared or not;
d) injury sustained while in the armed forces (land, water or air) of any country or international authority;
e) repair or replacement of existing dentures, partial dentures, braces, fixed or removeable bridges, or other artificial dental restoration;

f) repair, replacement, examinations for prescriptions or fitting of eyeglasses or contact lenses;
g) repair or replacement of artificial limbs or orthopedic braces.

Please note that airline travel is covered, but learning to fly, parachuting, etc. are not covered.

Should it be necessary to file a claim, please keep the following in mind:

* Notice of claim must be filed within 30 days after a covered loss occurs.

* All claim forms must be filled out completely and signed by the local coordinator in the appropriate place, certifying that the injured person is a Y.O.U. member or staff. A completed sample claim form is attached for your guidance.

* Claims should be sent directly to the insurance company. <u>Do not send them to Pasadena.</u> This will only delay processing. Please mail to: Hartford Insurance Group
  Health Claims Office
  P.O. Box 11910
  Alexandria, VA 22312

* Additional claim forms are available from the Y.O.U. office in Pasadena. A copy of the claim form is attached. Please copy it for repeated use.

* Accidents occuring outside the United States should be paid for first with local currency (unless it is a major loss, ie. over $1,000), then file the claim and ask to be reimbursed. This helps to avoid confusion about conversion of foreign currency.

* Once a claim has been filed, subsequent bills should be sent to the insurance company with a cover letter, restating the name of the injured person and the date of the injury.

While we hope our Y.O.U. members and staff will not need this insurance (please encourage safety), we are grateful to be able to provide this coverage to 10,000 Y.O.U. members and staff in the U.S., all for a cost of $10 per year, per person.

Please feel free to communicate with the Insurance Department should you have any additional questions about this insurance or how it works.

Notice of Claim
Youth Group, Sports or
Campers Policies

THE HARTFORD

HARTFORD ACCIDENT AND INDEMNITY COMPANY
TO BE COMPLETED BY LEADER OR OTHER OFFICIAL

SECTION I

Policy Number: 72 SR 610817
Policy Period: 1/1/87 to 12/31/87
Name and Location of Agent: Western Insurance Assoc. 1010 E. Union Pasadena, CA 91106

Name of School or Organization (if Sportsteam, give Name of League and Team): Youth Opportunities United

Address of School or Organization: 300 W. Green Street Pasadena, CA 91129

Name and Address of Student Member or Camper: Johnny M. Mishap, Jr. 798 Cedar Court Pasadena, CA 91101
Age: 16

Name and Address of Hospital: Huntington Hospital 100 Congress Street Pasadena, CA 91104
Date Entered Hospital: 1/25/87

Name and Address of Attending Physician: Dr. Syphus 1016 E. Green Street Pasadena, CA 91101

DUE TO ACCIDENT

Date and Time of Accident: 1/25/87 1:15 pm
Place of Accident: Ambassador College Campus

Nature of Injury: Severely twisted ankle, abrasions, contusions

What Caused the Accident? Tripped and fell

Describe Type of Sport or Activity Engaged in at Time of Accident: Running in the 2 mile run.

Name of Supervisor of the Activity: John Vierra

Witness to Accident (Name and Address): Stephen Glover

DUE TO ILLNESS

Nature of Illness:
Date Illness Commenced:

I hereby certify that the above is a member of the group insured under Policy No. ______ and that the above injury or sickness was sustained while participating in official activities under adequate organizational supervision. If a scouting group, give date of member's registration with the Council. ______ 19 ___

Youth Opportunities United Coordinator
TITLE OF OFFICIAL

OFFICIAL'S SIGNATURE [signature]

ADDRESS 1313 Bryant, Pasadena, CA 91103
DATE January 25 19 87

SECTION II

TO BE COMPLETED BY CLAIMANT

To whom are payments to be made? ☐ Claimant ☒ Doctor ☒ Hospital

Address of ☐ Claimant ☒ Doctor ☒ Hospital See above

Are there Medical Benefits available from any other source? ☐ Yes ☐ No. If yes, specify nature of other policy or plan and name of insurer or organization from whom benefits are available ______

COMPLETE ONLY IF CLAIMING DISABILITY BENEFITS

Date Total Disability Began N/A 19 ___ ☐ A.M. ☐ P.M.
Date Total Disability Ended ______ 19 ___ ☐ A.M. ☐ P.M.
Normal Occupation:
Duties Unable to Perform:
Name and Business Address of Employer:

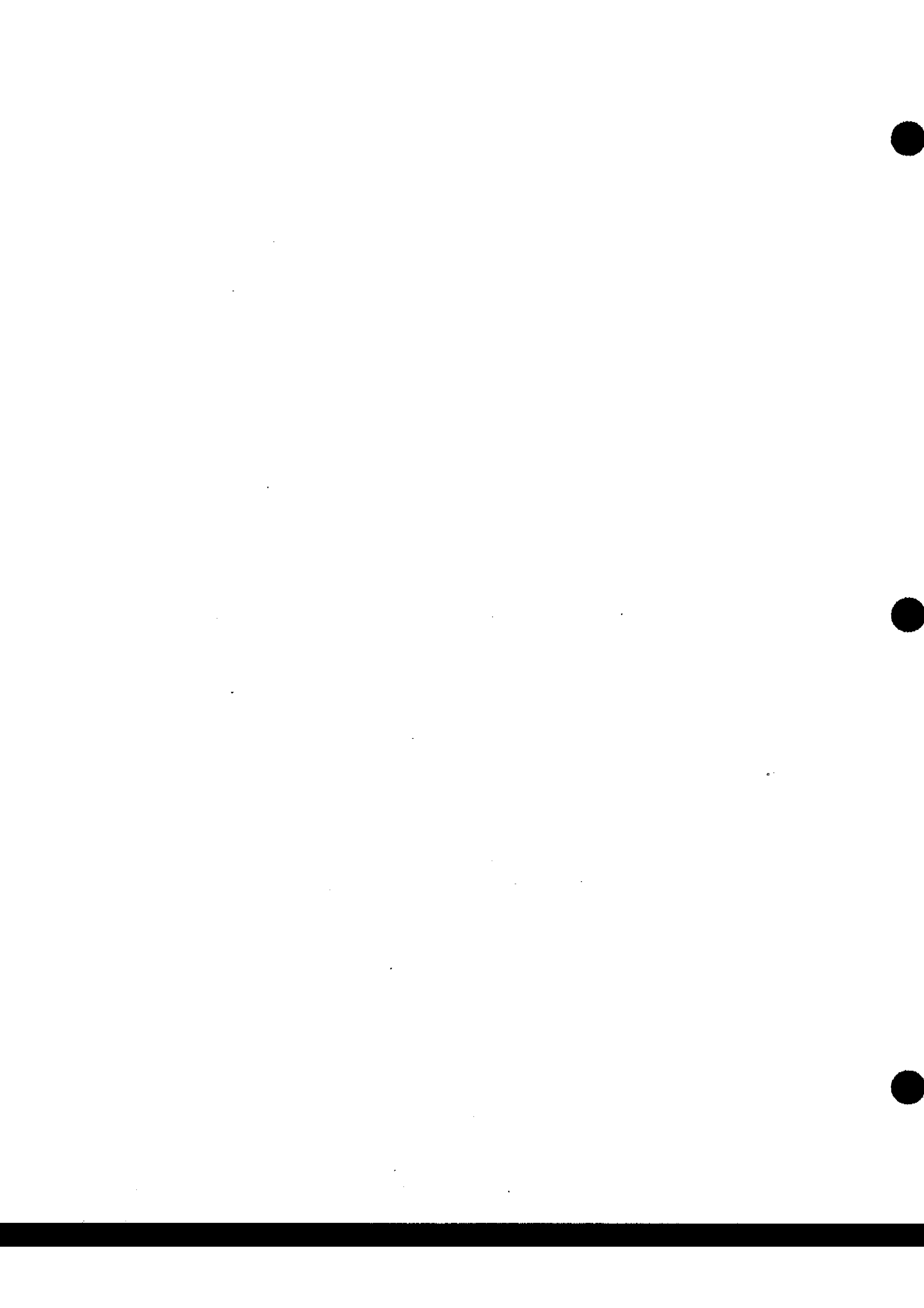
I hereby authorize any physician who has attended me or may attend me or any hospital where I may have been a patient, or any other individual or association who may have given me medical treament or supplies to disclose any information thus acquired. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Patient's signature — if claim is for other than minor child: [signature: John M. Mishap, Jr.]
Date: January 25, 1987

Signature of Parent — if claim is for minor
Date:

ITEMIZED BILLS FOR HOSPITAL AND MEDICAL TREATMENT MUST BE ATTACHED HEREWITH.

Form LC-4028-8 Printed in U.S.A. *Attending Physician Must Complete the Reverse Side of this Form.*



Notice of Claim
Youth Group, Sports or Campers Policies

THE HARTFORD

HARTFORD ACCIDENT AND INDEMNITY COMPANY

Policy Number	Policy Period	Name and Location of Agent

To be Completed by LEADER OR OTHER OFFICIAL

Name of School or Organization (if Sportsteam, give Name of League and Team)

Address of School or Organization

Name and Address of Student Member or Camper	Age

Name and Address of Hospital	Date Entered Hospital

Name and Address of Attending Physician

DUE TO ACCIDENT	Date and Time of Accident	Place of Accident
	Nature of Injury	
	What Caused the Accident?	
	Describe Type of Sport or Activity Engaged in at Time of Accident	
	Name of Supervisor of the Activity	
	Witness to Accident (Name and Address)	
DUE TO ILLNESS	Nature of Illness	Date Illness Commenced

I hereby certify that the above is a member of the group insured under Policy No. ______________ and that the above injury or sickness was sustained while participating in official activities under adequate organizational supervision. If a scouting group, give date of member's registration with the Council. ______________ 19 ______

Title of Official ______________ Official's Signature ______________

Address ______________ Date ______________ 19 ______

To be Completed by STUDENT, MEMBER OR CAMPER

To whom are payments to be made? ☐ Patient ☐ Doctor ☐ Hospital

Address of
☐ Patient ☐ Doctor ☐ Hospital

Are there Medical Benefits available from any other source? ☐ Yes ☐ No. If yes, specify nature of other policy or plan and name of insurer or organization from whom benefits are available ______________

COMPLETE ONLY IF CLAIMING DISABILITY BENEFITS	Date Total Disability Began ______ 19 ____ ☐ A.M. ☐ P.M.	Date Total Disability Ended ______ 19 ____ ☐ A.M. ☐ P.M.
	Normal Occupation	Duties Unable to Perform
	Name and Business Address of Employer	

I hereby authorize any physician who has attended me or may attend me or any hospital where I may have been a patient, or any other individual or association who may have given me medical treament or supplies to disclose any information thus acquired. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Patient's signature — if claim is for other than minor child	Date
Signature of Parent or Guardian — if claim is for minor	Date

ITEMIZED BILLS FOR HOSPITAL AND MEDICAL TREATMENT MUST BE ATTACHED HEREWITH.

Form LC-4028-7 Printed in U.S.A.

Attending Physician Must Complete the Reverse Side of this Form.