Markel Insurance Company

Evanston, Illinois 60201

(A Stock Insurance Company, Herein Called the Company)

POLICY NUMBER: MAR20275

AGREES with the Policyholder, named below in consideration of the payment of the premium and subject to the limits of liability, exclusions conditions and other terms of the policy:
TO PAY the benefits described in Item 4, Coverage.

SECTION I SCHEDULE

1. Name of Policyholder: Board of Trustees, University of Arkansas
   Address: Administration Building University of Arkansas
   Fayetteville, AR 72701

2. Policy Period: From August 7, 2017 to August 7, 2018
   at 12:01 A.M. Standard Time at your mailing address shown above.

3. Class of Insured Persons: Class I: All Participants of the Policyholder for whom premium has been paid.

   Description of Hazards Covered: An Insured Person will be covered for losses incurred while: (1) travel and lay – over on various sponsored and supervised trips of the policyholder and return. Coverage begins at the actual start of the trip from the original point of departure and ends when the insured person arrives at the return destination point.

4. Coverage:

THE POLICY CONSISTS OF THE FOLLOWING COVERAGE PARTS AND RIDERS. THE BENEFIT AMOUNT SHOWN IS THE LIMIT SELECTED BY THE POLICYHOLDER. IF THE COVERAGE WAS NOT REQUESTED BY THE POLICYHOLDER, THAT IS INDICATED BY THE WORD NIL. THE PREMIUM FOR EACH COVERAGE IS ALSO SHOWN AS IS THE TOTAL PREMIUM AT THE BOTTOM OF THE SCHEDULE.

COVERAGE	BENEFIT AMOUNT	PREMIUM
AGGREGATE LIMIT OF INDEMNITY	$600,000.	INCL.
ACCIDENT MEDICAL EXPENSE BENEFIT		INCL.
DEDUCTIBLE AMOUNT	$25.	
COINSURANCE PERCENTAGE	100%	
BENEFIT PERIOD	52 Weeks	
AGGREGATE MAXIMUM	$7,500.	
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS		INCL.
PRINCIPAL SUM	$15,000.	
SICKNESS MEDICAL EXPENSE BENEFIT		INCL.
DEDUCTIBLE AMOUNT	NIL	
COINSURANCE PERCENTAGE	NIL	
BENEFIT PERIOD	NIL	
AGGREGATE MAXIMUM	NIL	
CATASTROPHIC INJURY BENEFIT		INCL.
BENEFIT MAXIMUM	NIL	
MONTHLY INSTALLMENT	NIL	
TOTAL TEMPORARY DISABILITY BENEFIT		INCL.
BENEFITS COMMENCE WITH THE	NIL DAY	
RATE PER WEEK	NIL	
PERCENT OF BASIC EARNINGS	NIL	
MAXIMUM PERIOD	NIL WEEKS	
		TOTAL: See Schedule of Premium Rates

5. Form(s) and endorsement(s) made a part of the policy at the time of issue:

MSR100, MSR101, MSR128AD, MSR128bp, MSR128d, MSR102

Countersigned by _____
Licensed Resident Agent

BLANKET ACCIDENT AND HEALTH POLICY

MSR 101 (1/95)

McNair & Associates

TELEPHONE
479-521-7800
FACSIMILE
479-521-8617

COMPLETE INSURANCE SERVICE SINCE 1879

POST OFFICE BOX 819
FAYETTEVILLE, ARKANSAS 72702-0819

July 14, 2017

University of Arkansas
c/o James Ezell
Administration Building #321
Fayetteville, AR 72701

Dear Mr. Ezell & Ellen,

Enclosed please find your actual policy from the Markel Insurance Company for the student travel policy. As mentioned earlier the rates for the student travel policy remained the same for this term.

We hope that you have found this renewal policy in order. Please let me know if you have any additional questions and we thank you again for allowing us to help you with your insurance needs. Summer blessings to all.

Yours truly,

Mark McNair

First Health.

HSR
Health Special Risk, Inc.

Policy Name: _____

Policy Number: _____

School Name (if applicable): _____

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO *HSR*

E-mail : claims@hsri.com

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (800) 328-1114

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)	2. Social Security Number	3. Gender ☐M ☐F	4. Date of Birth	5. E-Mail

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

7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident	9. Place where Accident Occurred	10. The injured person was a: ☐ Participant ☐ Staff Member ☐ Guest ☐ Volunteer

Dental Claims	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐YES ☐NO

14. Describe How Accident Occurred – Give All Possible Details

15. 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 on the job (if applicable)?	☐YES	☐NO
D.	While traveling directly and uninterruptedly to or from home and policyholder premises?	☐YES	☐NO
E.	During intercollegiate/scholastic athletic practice? ☐YES ☐NO or competition?	☐YES	☐NO

16. Name of Event or Activity	17. Name and Title of Supervisor

18. Name of Policyholder

20. Signature of Policyholder Representative	21. Title of Policyholder Representative	22. Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant 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 your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	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, submit proof of payment)**

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined 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. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

MARKEL®

PRIVACY NOTICE

We are committed to safeguarding your privacy. We understand your concerns regarding the privacy of your nonpublic personal information. No nonpublic personal information is required to be collected when you visit our websites; however, this information may be requested in order to provide the products and services described. We do not sell nonpublic personal information to non-affiliated third parties for marketing or other purposes. We only use and share this type of information with non-affiliated third parties for the purposes of underwriting insurance, administering your policy or claim and other purposes as permitted by law, such as disclosures to insurance regulatory authorities or in response to legal process. Notwithstanding the foregoing, we may use this information for the purpose of marketing our own products and services to you.

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and/or
- Information we receive from consumer reporting agencies and inspection reports.

We do not disclose any nonpublic personal information about our customers/claimants or former customers/claimants to anyone, except as permitted by law.

We may disclose nonpublic personal information about you to the following types of third parties:

- Service providers, such as insurance agents and/ or brokers and claims adjusters; and/or
- Other non-affiliated third parties as permitted by law.

We restrict access to nonpublic personal information about our customers/claimants to those individuals who need to know that information to provide products and services to our customers/claimants or as permitted by law. We maintain physical, electronic, and procedural safeguards to guard your nonpublic personal information.

Residents of California:

You may request to review and make corrections to recorded non-public personal information contained in our files. A more detailed description of your rights and practices regarding such information is available upon request. Please contact your agent/broker for instructions on how to submit a request to us.