COVER SHEET

Accident & Health

POLICY NUMBER: 4102AH282411 - 8

MIC INVOICE(01/95)	Markel Insurance Company Invoice
M-SR100(01/95)	BLANKET SPECIAL RISK A&H POLICY
MSR101(01/95)	SCHEDULE OF INSURANCE
MPN-GLB(07/01)	NOTICE OF MARKEL INS. COMPANY'S PRIVACY POLICY
MSR-CF-HSR(04/10)	SPECIAL RISK CLAIM FORM - HSR
MSR128(01/04)	2004 ACCIDENT DEFINITION
MSR128(01/95)	HMO/PPO NOT COVERED
MSR128-AD(03/96)	MIC ADDRESS CHANGE
MSR128-BP(08/00)	BENEFIT PERIOD
MSR128-IL(03/96)	ILLINOIS AMENDATORY ENDORSEMENT
MSR200(01/95)	COORDINATION OF BENEFITS FOR ACCIDENT MEDICAL EXPENSE
PN-MEP(02/09)	NOTICE TO POLICYHOLDER - MINIMUM PREMIUM

Producer Copy

A STOCK COMPANY

MARKEL INSURANCE COMPANY
Shand Morahan Plaza, Evanston, Illinois 60201

BLANKET ACCIDENT AND HEALTH POLICY SPECIAL RISK

THE ATTACHED DECLARATIONS PAGE, SPECIAL POLICY CONDITIONS, FORMS, AND ENDORSEMENTS COMPLETE THIS POLICY.

SECTION 5 POLICY PROVISIONS

Entire Contract; Changes

This Policy and endorsements signed by the Policyholder and Insurer are the entire contract. Any change, modification or waiver of this Policy or a certificate issued under it must be in writing and signed by one of the following: our President; our Vice-President; a Secretary; or Assistant Secretary.

Grace Period

This Policy has a 31 day Grace Period. If the premium is not paid by the due date, it may be paid during the 31 days immediately following the due date. The Policy will remain in force during the Grace Period. The Grace Period does not apply:

(a) to the first premium due; or
(b) to premiums due thereafter if we have given you 60 days prior notice that we will not renew the Policy.

Notice of Claim

Notice of Claim must be given to us within 30 days after a Loss occurs, or as soon thereafter as possible. The notice can be given to us at P.O. Box 2039, Glen Allen, VA 23058-2039. Notice should include the Insured Person's name and Policy Number.

Claim Forms

When we receive the Notice of Claim, we will send the Insured Proof of Loss forms. If we do not send these forms within 15 days, the Insured can meet the Proof of Loss requirement by giving us a written statement of the nature and extent of Loss within the time limit in the Proofs of Loss Section.

Proofs of Loss

Written Proof of Loss must be given to us within 90 days after such Loss. We will not deny or reduce any claim because proof is not filed within this time, if it is filed as soon as reasonably possible. In any event, the proof required must be given, unless the claimant is legally incapacitated.

Time of Payment of Claims

After receiving written Proof of Loss, we will immediately pay all benefits as they accrue.

Payment of Claims

After receiving written Proof of Loss, we will pay all benefits to the Insured, if living, or at the Insured's request, to the Hospital or person rendering services. It is not required that the service be rendered by a particular Hospital or person.

Benefits for accidental death, if any, will be paid to the named beneficiary, other than the policyholder or an officer thereof, if then living. If no beneficiary is named, or the named beneficiary predeceases the Insured, such benefits will be paid to the Insured's estate.

Discontinuance of this Policy will not prejudice any claim incurred while this Policy is in force.

Physical Examination

We, at our expense, have the right to have any Insured examined by a Physician of our choice as often as reasonably necessary, while a claim is pending.

Legal Actions

No legal action may be brought to recover on this Policy: (a) within 60 days after written Proof of Loss has been given as required; or (b) after 6 years from the time written Proof of Loss is required, or after the expiration of the applicable statute of limitations, if greater.

Change of Beneficiary

The Insured can change the beneficiary at any time giving us written notice. The beneficiary's consent is not required for this or any other change in the coverage.

Conformity With State Statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which it is issued or in which the Insured Person resides, is hereby amended to conform to the minimum requirements of such statutes.

Assignment

This policy and an Insured's coverage may not be assigned.

Records Maintained

You must maintain adequate records of this insurance.

Examination and Audit

At any reasonable time and for any purpose relating to this Policy, your records shall be open for our inspection and audit. Such examination may be made during the Policy term; within 3 years after the Policy is terminated; or until final settlement of all claims hereunder, whichever is later.

Subrogation

When benefits are paid to or for an Insured Person under the terms of this Policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured Person once the Insured has been indemnified for his Loss, against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury or Sickness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by us of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

Right of Recovery

Payments made by us which exceed the Covered Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder, shall be recoverable by us from or among any persons, firms, or corporations to or for whom such payments were made.

Workers' Compensation

This Policy is not in place of and does not affect any requirement for such coverage by workers' compensation insurance.

SECTION 6 COVERAGE

All Policy benefits are as indicated in Section 1 - Schedule of Insurance and as described herein, or in riders attached to and made a part of this Policy.

Accident Medical Expense Benefit

When an insured's Injury requires:

(a) treatment by a Physician;
(b) Hospital services;
(c) services of a licensed practical nurse or RN;
(d) x-ray service;
(e) use of operating room, anesthesia (including the administration thereof), laboratory service;
(f) use of an ambulance;
(g) use of an Ambulatory Surgical Center or Ambulatory Medical Center;
(h) if ordered by a Physician, prescription medicines, drugs, or any other therapeutic services or supplies; or
(i) Home Health Care Expenses,

Policy Number **4102AH282411-8**

Markel Insurance Company

Evanston, Illinois 60201

(A Stock Insurance Company, Herein Called the Company)

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: Orland Park Magic Sports Association
   Address: P. O. Box 2546
   Orland Park, IL 60462

2. Policy Period:From 11-05-2013 to 11-05-2014 at 12:01 A.M. Standard Time at your mailing address shown above.

3. Class of Insured Persons:
   All registered participants and volunteers for whom premium has been paid.

   Description of Hazards Covered:
   Insured persons are covered for Injury resulting from an Accident which occurs directly from: 1) activities that are scheduled, sponsored or supervised by the policyholder; 2) premises owned, leased or borrowed by the policyholder; or 3) travel scheduled, sponsored or supervised by the policyholder.

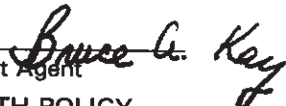
4. Coverage:

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	$250,000	INCL.
ACCIDENT MEDICAL EXPENSE BENEFIT		INCL.
DEDUCTIBLE AMOUNT	$0	
COINSURANCE PERCENTAGE	100%	
BENEFIT PERIOD	52 Weeks	
AGGREGATE MAXIMUM	$25,000	
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS		INCL.
PRINCIPAL SUM	$5,000	
SICKNESS MEDICAL EXPENSE BENEFIT		N/A
DEDUCTIBLE AMOUNT	NIL	
COINSURANCE PERCENTAGE	NIL	
BENEFIT PERIOD	NIL	
AGGREGATE MAXIMUM	NIL	
CATASTROPHIC INJURY BENEFIT		N/A
BENEFIT MAXIMUM	NIL	
MONTHLY INSTALLMENT	NIL	
TOTAL TEMPORARY DISABILITY BENEFIT		N/A
BENEFITS COMMENCE WITH THE	NIL DAY	
RATE PER WEEK	NIL	
PERCENT OF BASIC EARNINGS	NIL	
MAXIMUM PERIOD	NIL WEEKS	
	TOTAL:	$895

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

M-SR100(01/95), MSR101(01/95), MSR128(01/95), MSR128(01/04), MSR128-BP(08/00), MSR200(01/95), MSR128-AD(03/96), MSR128-IL(03/96)

Countersigned by Bruce A. Kay  Producer

Licensed Resident Agent

MSR101 (1/95)

BLANKET ACCIDENT AND HEALTH POLICY

Markel Insurance Company

NOTICE OF MARKEL INSURANCE AND MARKEL AMERICAN INSURANCE COMPANY'S PRIVACY POLICY

September 13, 2013

While information is the cornerstone of our ability to provide superior service to you, our most important asset is our customer's trust. Keeping customer information secure is a top priority for all of us at Markel. We intend to use information collected only in the normal course of our business and as permitted by law. Following is our privacy policy to our individual customers.

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
* Information we receive from a consumer reporting agency.

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

We may disclose nonpublic personal information about you to third party financial service providers, such as your insurance agent and/or broker. We may also disclose nonpublic personal information about you to non-affiliated third parties as permitted by law.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with applicable standards to guard your nonpublic personal information.

For further information, please contact us at 1-800-431-1270.

IMPORTANT PRIVACY NOTICE - PLEASE READ

Markel is committed to safeguarding your privacy. We understand your concerns regarding the privacy of your nonpublic personal financial information, and want to assure you that we do not sell this information to anyone for marketing or other purposes. We only use and share this type of information with non-affiliated third parties for purposes of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosures to insurance regulatory authorities or in response to legal process.

Federal law and the various state insurance departments regulate what types of disclosures are acceptable. For example, we are permitted to disclose nonpublic personal financial information as necessary to administer your policy or claim. Representative types of non-affiliated third parties that may be involved in your insurance transaction include the following individuals or organizations:

* Your insurance agent, broker or agency.
* A government agency or other organization pursuant to an examination of our records and/or practices.
* Your attorney, trustee or anyone else who has a legal interest in your policy.
* Persons to whom a court requires us, by order or subpoena, to provide information.
* Claims adjusters or investigators.
* An insurance support organization to prevent or prosecute fraud.
* Insurance rate advising organizations.
* Reinsurers.

We have and maintain strict policies and procedures to protect the confidentiality of your nonpublic personal financial information. We maintain physical, electronic and procedural safeguards to protect this information from unauthorized access. Access to your information is restricted to those individuals having a business need for such information.

At Markel, we take your privacy very seriously. Enclosed you will find our privacy notice with your policy.

Return Completed form to:
Health Special Risk HSR Plaza II
4100 Medical Parkway
Carollton, TX 75007
P: 888-765-7223
F: 972-512-5820
claims@hsri.com

Special Risk Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.

In order to pay claims we must have your Social Security Number

Claim procedures, online access to our claim form, and our privacy policy are available from our website at: **www.MarkelAH.com**

Part 1- POLICYHOLDER'S REPORT

Name of School		Name of Policyholder Orland Park Magic Sports Association			Policy Number 4102AH282411-8
Claimant's Name		Gender ☐ Male ☐ Female			Date of Birth
Social Security Number (Required)		Email Address			
Claimant's Address		City	State	Zip	Phone Number
Parent's Name (if applicable)	Parent's Address (if applicable)	City	State	Zip	Phone Number

1. Date and time of accident:__________ Place where the accident occurred?__________
2. Was the injured person? ☐ Participant ☐ Staff Member ☐ Guest ☐ Volunteer

FOR DENTAL CLAIMS ONLY

3. Indicate which teeth were involved in the accident:__________
4. Describe condition of injured teeth prior to accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial
5. Nature of Injury:__________ (indicate part of body injured- e.g. broken arm, sprained ankle, etc.)
6. Describe how the accident occurred- give all possible detailed- must be a bodily injury due to accident:__________
7. Did the accident occur?
   A. During a policyholder sponsored & supervised activity? ☐ Yes ☐ No
   B. During programmed hours? ☐ Yes ☐ No
   C. On activity premises? ☐ Yes ☐ No
   D. While traveling directly to or from a sponsored event? ☐ Yes ☐ No
   E. During a USGF sanctioned event (Gymnastics schools only) or competition? ☐ Yes ☐ No
8. Name of the event or activity:__________ Name and Title of Supervisor:__________
9. Representative Signature__________ Title__________ Date:__________

Part 2- OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health coverage through an employer or other sounce on you? ☑ Yes ☐ No
If yes, Name of insurance company__________ Policy #__________
Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐ Yes ☐ No
If Yes, Name of insurance company__________ Policy #__________

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 Markel Insurance Company to the extent of any amount collectible.
Signature of Volunteer:__________ **Witness:**__________ **Date:**__________

AUTHORIZATION FOR RELEASE OF INFORMATION

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative s Signature: __________ **Date:**__________

If Authorized Representative, Relationship to Patient or Legal Designation:__________

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative s Signature: __________ **Date:**__________

If Authorized Representative, Relationship to Patient or Legal Designation:__________

PLEASE NOTE

In furnishing this or other claim forms fro the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

Markel Insurance Company

Endorsement No. 1

For the premium charged and paid it is agreed that:

MSR100, SECTION 2, DEFINITIONS:

ADD: Accident means a sudden, unexpected and unintended event which is identifiable and caused solely by an external physical force resulting in Injury to an Insured person. Accident does not include a Loss due to or contributed to by disease or Sickness.

This rider is attached to and becomes a part of this Policy.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 11-05-2013 Attached to and forming part of Policy No. 4102AH282411-8

of Markel Insurance Company

issued to Orland Park Magic Sports Association

President

Secretary

MSR128 (1/04)

Markel Insurance Company

Evanston, Illinois 60201

Endorsement No. C

When charges incurred by a claimant are covered under a Health Maintenance Organization (HMO) plan or a Preferred Provider Organization (PPO) plan, and are denied due to the claimant's failure to precertify, this plan will not pay medical benefits.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 11-05-2013 Attached to and forming part of Policy No. 4102AH282411-8

of Markel Insurance Company

issued to Orland Park Magic Sports Association

President

Secretary

MSR128 (1/95)

Markel Insurance Company

Endorsement No. 1

Markel Insurance Company's address is hereby changed to:

Markel Insurance Company
Ten Parkway North
Deerfield, Illinois 60015

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 11-05-2013 Attached to and forming part of Policy No. 4102AH282411-8

of Markel Insurance Company

issued to Orland Park Magic Sports Association

President

Secretary

MSR128-AD (3/96)

Markel Insurance Company

Endorsement No. 1

It is hereby understood and agreed:

SECTION 2, DEFINITIONS:

"Benefit Period" means the time during which an Insured Person's incurred expense for a covered injury or sickness is eligible for reimbursement. The "Benefit Period" selected starts on the date of the accident for an injury or the date of the first treatment for a sickness.

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date 11-05-2013 Attached to and forming part of Policy No. 4102AH282411-8

of Markel Insurance Company

issued to Orland Park Magic Sports Association

President

Secretary

MSR128bp

Markel Insurance Company

Evanston, Illinois 60201

ILLINOIS AMENDATORY ENDORSEMENT

MSR100-SECTION 7- EXCLUSIONS:

Exclusion 13: REPLACE with: All types of hernia.

ADD Exclusion18: False labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy as defined in Section 2 Definitions.

This endorsement is attached to and becomes a part of this Policy.

President

Secretary

MSR128-IL (3/96)

Markel Insurance Company

Evanston, Illinois 60201

COORDINATION OF BENEFITS FOR ACCIDENT MEDICAL EXPENSE BENEFITS

Such insurance as is afforded by this policy for Accident Medical, are payable only in excess of any expenses payable by other valid and collectible insurance. In the absence of other valid and collectible insurance, it is our intention that expenses incurred in connection with any covered injury shall be fully payable subject to the terms, conditions and limitations of the Policy.

"Other valid and collectible insurance" shall mean any plan providing medical expense benefits for or by reason of dental, physician, nurse, hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by (1) any type of service plan contracts, any group or blanket insurance, employee benefit plan or any plan arranged through an employer, trustee, union or employee benefit association, or (2) any plan or program created or administered by national or state government, or agencies thereof, (3) individual insurance. We will not limit or exclude payment on a claim because the Insured is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act.

This provision shall apply in determining the benefits as to a person covered under this plan for any claim determination period. If an Expense exceeds the amount of benefit payable under any other valid and collectible insurance for such person during such time period, the Company will pay such excess Expenses incurred due to a covered injury.

This rider is attached to and becomes a part of the Policy.

President

Secretary

MSR200 (1/95)

Markel Insurance Company

NOTICE TO POLICYHOLDERS

The policy to which this notice is attached is subject to a minimum, fully earned premium of $350.

Should you have any questions regarding this, such questions should be directed to us (the Company) or to your agent.