



FLOYD COUNTY BOARD OF EDUCATION
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Linda C. Gearheart, Board Chair - District 1
William Newsome, Jr., Vice-Chair - District 3
Dr. Chandra Varia, Member - District 2
Keith Smallwood, Member - District 4
Steve Slone, Member - District 5

Consent Agenda Item (Action Item): Prestonsburg High School Football parent boosters is requesting permission to use the turf facility at Prestonsburg High School and the campus of Allen Elementary for their fully insured flag football league.


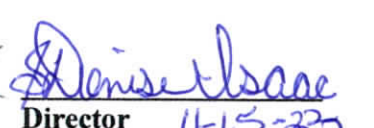
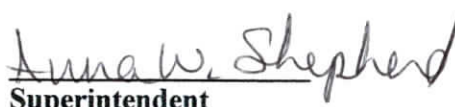
Applicable Statute or Regulation: Board Policy 01.11 General Powers and Duties of the Board of Education

Fiscal/Budgetary Impact: No financial responsibilities. Prestonsburg High School Football parent boosters will cover all cost and liabilities.

History/Background: Prestonsburg High School is continuing to attempt to increase overall participation at the high school level. By engaging the youth, the league will provide a foundational structure to increase high school participation.

Recommended Action: Floyd County Board of Education allows Prestonsburg High School Football parent boosters is requesting permission to use the turf facility at Prestonsburg High School and the campus of Allen for their fully insured flag football league.

Contact Person(s): Brandon Patton, Booster President/ 606-791-4048
Bryan Allen, Booster Vice President/ 606-791-2565
Ricky Thacker, Principal/ 606-886-2252


Principal

Director

Superintendent

Date: 10-21-2022

Application and Agreement for Use of District Property

NOTE: Please complete this form in duplicate and submit both copies to the Central Office designee for approval. If the application is approved, one (1) copy of the signed agreement will be returned to the using organization along with a contract prepared by the Board attorney. The contract shall be signed by the designated representative of the using organization and returned to the Central Office designee. If the application is not approved, both copies will be returned.

Name of Sponsoring Organization/Activity <u>PHS Parent Football Boosters, INC</u>		Telephone <u>606-791-4648</u>
Representative's Name <u>Brandon Patton</u>		
Address <u>3004 South Lake Dr. Prestonsburg, Ky 41653</u>		
The above organization/individual requests the use of:		
<input type="checkbox"/> auditorium	<input type="checkbox"/> gymnasium	<input type="checkbox"/> dining room/kitchen
<input type="checkbox"/> classroom(s)	<input type="checkbox"/> other, specify _____	<input checked="" type="checkbox"/> stadium
Is the organization planning to use District-owned equipment? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
If yes, specify equipment _____ Operator's Name _____		
Is the organization planning to conduct sales on school premises? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
If yes, give a complete description of what is being sold and how the proceeds will be used. _____		
Building/school/facility <u>PHS/Allen Elementary Football fields</u>		
Purpose <u>Flag Football</u>		
Date(s) requested <u>10-1-22 - 10-1-23</u>		Time(s) Requested <u>Various</u>
Will public be admitted?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Will advertisement(s) be used?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Will admission be charged?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

When using school facilities, this organization agrees to observe the following:

- To schedule with the building Principal the time(s) District **property is to be used**. It is understood that the Superintendent/designee may cancel the use of the room or building at any time such use interferes with regular school activities.
- To be legally responsible for any and all damage to individuals and school equipment, building(s), grounds, or facilities, resulting from use by the organization. To this end, the organization will procure sufficient liability insurance to indemnify the Board, school officers and employees for any injuries or property damage which might occur during the organization's use of the facilities. This insurance shall contain limits of \$1,000,000 for bodily injury and \$10,000 for property damage. A copy of the organization's insurance certificate shall be filed with the Board prior to the date the organization uses the building. The Board shall require the renting organization to assume all liability for injury to individuals by reason of the lease of Board property and that the organization indemnify and save harmless the Board from any loss or damage thereby.
- To provide appropriate equipment for the use of District property. When gymnasiums are used, the organization agrees to permit on the gym floor only those persons wearing shoes that will not mark the floor.
- To abide by the requirements of Board Policies 05.3 and 05.31 (see attached). Disregard of the rules and regulations governing the use of the school buildings, equipment and facilities shall result in the refusal of the Board to grant the offending organization further use.
- To acknowledge that approval of this request does not signify District sponsorship, endorsement or approval of your organization or the activity.

SCHOOL FACILITIES

05.31 AP.21
(CONTINUED)**Application and Agreement for Use of District Property****FEE SCHEDULE**

The organization agrees to pay the applicable fee(s) for the use of District facilities.

	# of Employees Required	# of Hours	Hourly Rate (Overtime at 1.5 times)	Total
Custodians				
Food Service Employees				
Supervisory Personnel				
Other _____				
TOTAL PERSONNEL CHARGE				

Property Used	Facility/ Equipment Fee	Personnel Cost, if applicable	Insurance cost, if applicable	Total Cost for Facility Use
Gymnasium at _____ school				
Auditorium at _____ school				
Cafeteria - <input type="checkbox"/> Dining Room <input type="checkbox"/> Kitchen <input type="checkbox"/> Both at _____ school				
Classroom(s) Number _____ at _____ school				
Stadium at <u>Prestonsburg High</u> school				
Other Property at <u>Allen Elementary</u> school				

RL Pelt
Signature - Representative of User Group

10-21-22
Date

Signature - Superintendent/designee

Date

IN THE EVENT SCHOOL IS CLOSED DUE TO WEATHER CONDITIONS, ALL SCHEDULED ACTIVITIES, WITH THE EXCEPTION OF DINNER MEETINGS, WILL BE CANCELED AND OPPORTUNITY TO RESCHEDULE OR REFUND RENTAL FEE(S) WILL BE MADE.

Application and Agreement for Use of District Property**For Office Use Only - To be Completed by School Official**

Cost for use of District property \$ _____ Cost for school employee \$ _____ Total cost \$ _____
Deposit \$ _____ Is deposit refundable? ☐ Yes ☐ No
Date Deposit Received _____ Balance Due \$ _____
Board employee(s) assigned: _____
Board Action Date, if applicable _____ Board Order # _____

Review/Revised:9/29/11

Berkley Life and Health Insurance Company

Urbandale, Iowa
Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690



Blanket Accident Policy

Policyholder: PHS Football Parent Booster Inc.

Policy Number: PAI L106020260201

Effective Date: September 26, 2022

State of Issue: Kentucky

This Policy is a legal contract between the Policyholder and Berkley Life and Health Insurance Company (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state where it was delivered.

Signed for the Company, as of the Effective Date above:

A handwritten signature in black ink, appearing to be 'L. M. B.', written over a horizontal line.

President

A handwritten signature in black ink, reading 'Philip S. Welt', written over a horizontal line.

Secretary

**THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
THIS IS A LIMITED POLICY.
PLEASE READ THE POLICY CAREFULLY.**

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SCHEDULE OF BENEFITS

POLICYHOLDER: PHS Football Parent Booster Inc.
POLICY EFFECTIVE DATE: September 26, 2022
POLICY NUMBER: PAI L106020260201
POLICY PERIOD: September 26, 2022 through November 26, 2022

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class.

Class 1 All registered participants, coaches, and volunteers of the Policyholder.

Premium

Total Amount Due: \$527.00

Premium Schedule: Annual paid 30 days From the Effective Date

Projected Number of Lives: 90

AGGREGATE LIMIT OF LIABILITY:

Benefit Maximum	\$100,000
Applies During	Per Covered Accident
Applies To	Accidental Death & Dismemberment Benefits only

HAZARDS INSURED AGAINST:

<u>Class</u>	<u>Description of Hazard</u>
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Class 1:	Supervised and Sponsored Activities
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Covered Activity(ies):

- While participating in sponsored, scheduled and supervised flag football activities of the Policyholder. Travel as a group is also included.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum:	\$10,000
Time Period for Loss:	365 days

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

AH51051-KY

Total Benefit Maximum for all Accident Medical	\$100,000
Loss Period (first Covered Expenses must be incurred within):	30 days after the date of the Covered Accident
Benefit Period:	52 weeks from the date of the Covered Accident
Deductible:	\$0
Coinsurance Factor for all Covered Expenses:	100%
Terms of Payment	Full Excess

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

COVERED EXPENSES means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy and indicated on the Schedule of Covered Losses.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy, who is a U.S. citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

DEDUCTIBLE means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident, before Accident Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under this Policy.

DOMESTIC PARTNER means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or

have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

EXTENDED CARE FACILITY means an institution operating pursuant to applicable laws, that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and registered nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

HOME HEALTH CARE means nursing care, treatment and Daily Living Services provided in the Covered Person's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

HOSPITAL means an institution that:

- 1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) provides 24-hour nursing service by registered nurses on duty or call;
- 3) has a staff of one or more licensed Physicians available at all times;
- 4) provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 6) is not a place for drug addicts, alcoholics or the aged.

Hospital also includes ambulatory surgical centers approved by the Kentucky health facilities and health services certificate of need and licensure board. Charges for health care treatment or services rendered by an ambulatory surgical center shall be covered on the same basis as charges for the same health care treatment or services rendered by a Hospital.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINED/HOSPITAL STAY means a stay/confinement of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

IMMEDIATE FAMILY means the Covered Person's parent, grandparent, spouse, Child(ren) (includes legally adopted or step Child(ren)), brother, sister, step-Child(ren), grandchild(ren), or in-laws.

INJURY means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICAL EMERGENCY means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

MEDICALLY NECESSARY means a treatment, service or supply that is:

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

PHYSICIAN means a legally licensed practitioner of the healing arts including, but not limited to, physicians, osteopaths, optometrists, certified surgical assistants, physician assistants, podiatrists, licensed nurses, chiropractors or dentists, practicing within the scope of his or her license to treat the condition causing loss. It does not include a member of the Covered Person's Immediate Family.

TELEHEALTH means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment and transfer of medical data.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means Berkley Life and Health Insurance Company underwriting this insurance.

YOU, YOUR, YOURS, HE or SHE means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the Classes of Eligible Persons shown on the Policy Schedule of Benefits, He or She is eligible to be covered on the Policy Effective Date. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

A Covered Person's Dependent(s), as applicable, are eligible on the latest of the date:

- 1) the Covered Person is eligible, if the Covered Person has Dependents on that date; or
- 2) the date the person becomes a Dependent

If the Covered Person is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under this Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

AH51051-KY

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:

- 1) the Policy Effective Date; or
- 2) the date such person becomes eligible, subject to any required waiting period, as described in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:

- 1) The Policy Termination Date shown in this Policy; or
- 2) The premium due date if premiums are not paid when due subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under this Policy ends on the earliest of:

- 1) The date this Policy terminates;
- 2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid;
or
- 4) The last day of the period for which premiums have been paid.

EXTENSION OF BENEFITS: In the event of a Covered Person's Total Disability at the date of termination of the Policy, benefits will be extended for such Covered Person for 90 days for Covered Medical Expenses incurred during the period of disability or incurred within a period of 90 days starting with a Covered Accident which occurred while coverage was in force.

PREMIUMS

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium is due on the Policy Effective Date. After that premium will be due monthly unless otherwise stated in the Policy.

- (2) not on Policyholder premises and attending or participating in a Supervised and Sponsored Activity.
- (3) Travel as part of group in transportation authorized or arranged by the policyholder; or

"Supervised and Sponsored Activity" means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.

DESCRIPTION OF BENEFITS

All benefits payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Time Period for Loss as shown in Schedule of Benefits, the Company will pay the percentage of the Principal Sum shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit, the largest, will be paid for all Covered Losses due to the same Covered Accident.

Schedule of Covered Losses

<u>Loss of:</u>	<u>Benefit:</u>
	(Percentage of Principal Sum/Amount of Insurance)
Life.....	100%
Quadriplegia.....	100%
Two or More Members.....	100%
One Member.....	50%
Hemiplegia.....	50%
Paraplegia.....	50%
Uniplegia.....	25%
Thumb and Index Finger of the Same Hand.....	25%
Four fingers of the Same Hand.....	25%

"Loss of Member" means Loss of Hand or Foot, Loss of Arm or Leg, Loss of Sight, Loss of Speech and Loss of Hearing. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of Arm or Leg" means complete severance through or above the elbow or knee joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

"Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.

"Paraplegia" means total Paralysis of both lower limbs or both upper limbs.

"Quadriplegia" means total Paralysis of both upper and lower limbs.

"Uniplegia" means total Paralysis of one lower limb or one upper limb.

Aggregate Limit of Liability

The maximum amount the Company will pay for all Covered Losses resulting from the same Accident will not exceed the Aggregate Limit of Liability as described in the Schedule of Benefits.

If the total amount payable for all Covered Losses in any one Accident exceeds the Aggregate Limit of Liability, each Covered Person's Covered Loss will be paid at the same ratio that the Aggregate Limit of Liability has to the total amount of all Covered Losses. The Company shall not be liable for amounts in excess of the Aggregate Limit of Liability.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
- 3) for Covered Expenses incurred within 52 weeks after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses, from a Covered Accident, include:

- 1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
- 2) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
- 3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Registered Nurse Services Expenses for private duty nursing while a Covered Person is Hospital Confined, when services are ordered by a Physician.
- 5) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
- 6) Outpatient surgery expenses, including Ambulatory Surgical Center.
- 7) Outpatient surgical room and supply expenses for use of the surgical facility.
- 8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 9) Physician non-surgical treatment/examination expenses (excluding medicines) including the

Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.

- 10) Second surgical opinion expenses.
- 11) Physician surgical expenses. If an Injury requires multiple surgical procedures through the same incision, We will pay for only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
- 12) Assistant Surgeon expenses when Medically Necessary.
- 13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 14) Outpatient laboratory test expenses.
- 15) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 16) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 17) X-ray expenses (including reading charges) not including dental x-rays.
- 18) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 19) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Covered Accident.
- 20) Dental expenses related to the installation of crowns, caps, bridges and dentures; oral surgery and endodontics and repair or replacement of caps and crowns that existed prior to the Covered Accident.
- 21) Outpatient registered nurse services if ordered by a Physician.
- 22) Ambulance expenses for transportation from the Accident site to the Hospital.
- 23) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
- 24) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 25) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
- 26) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 27) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.
- 28) Services provided through Telehealth shall be covered the same as if provided through face-to-face consultation if the consultation is provided through the Telehealth network established under Kentucky law. A Telehealth consultation shall not be covered if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.
- 29) Charges for health care treatment or services rendered by ambulatory surgical centers approved by the Kentucky health facilities and health services certificate of need and licensure board. Charges for health care treatment or services rendered by an ambulatory surgical center shall be on the same basis as coverage provided for the same health care treatment or services rendered by a Hospital
- 30) If this optional benefit is elected by the Policyholder, We will cover expenses incurred for home health care if the attending Physician certifies that hospitalization or confinement in a skilled nursing facility would otherwise be required. We will cover a maximum of 60 visits per 12 month period. Each visit by an authorized representative of a home health agency shall be considered as one home health care visit except that at least four hours of home health aide

service shall be considered one visit.

Terms of Payment for Accident Medical and Dental Expense Benefit

Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor, Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions and/ or failure to utilize the network providers and facilities of His primary coverage will result in a benefit reduction of Covered Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- (1) group or blanket insurance, whether on an insured or self-funded basis;
- (2) hospital or medical service organizations on a group basis;
- (3) Health Maintenance Organizations on a group basis;
- (4) group labor management plans;
- (5) employee benefit organization plan;
- (6) professional association plans on a group basis; or
- (7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an accidental bodily Injury, unless otherwise covered under this policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Disease or disorder of the body or mind.
6. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
7. We shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of any narcotic or any hallucinogenic unless administered on the advice of a Physician.
8. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission

- or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
9. Conditions that are not caused by a Covered Accident.
 10. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
 11. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
 12. Travel or activity outside the United States.
 13. Participation in any motorized race or speed contest.
 14. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
 15. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.
 16. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
 17. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
 18. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person.
 19. Treatment of a hernia whether or not caused by a Covered Accident.
 20. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
 21. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
 22. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
 23. Mental or nervous disorders, except as specifically provided in this policy.
 24. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
 25. Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.
 26. Loss resulting from participation in any activity not specifically covered by this Policy.
 27. Any treatment, service or supply not specifically covered by this Policy.
 28. Eyeglasses, contact lenses, hearing aids.
 29. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in the Policy.
 30. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - ii. While being used for any test or experimental purpose; or
 - iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - iv. while traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.

Except as a fare paying passenger on a regularly scheduled commercial airline.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Cambridge Administrators, LLC, 5832 S 142nd St, Omaha, NE 68137, (855) 868-7554. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 180 days after the date of loss. If the proof of loss is not submitted within 180 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 180 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'.

EXPOSURE AND DISAPPEARANCE: A Covered Person will be presumed to have died due to covered Injuries, if while insurance is in effect He suffers Covered Loss due to exposure to the elements.

A Covered Person will be presumed to have died, if, while insurance is in effect and after the forced landing, stranding, sinking or wrecking of a covered vehicle:

- 1) He disappears; and
- 2) His body is not found within a year of the Accident; and
- 3) a valid death certificate or other legal proof of death is issued by a court of appropriate jurisdiction.

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error; or
- 2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

RIGHT OF RECOVERY: A Covered Person may incur charges due to an Injury for which benefits are paid by this Policy. The Injury may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made, the Covered Person must repay Us the Recovery made from: 1) the other person; or 2) the other person's insurer.

Only the amount recovered for charges incurred will be subject to Refund. One-third of the Net Recovery will be deemed to be for such charges. However, in no case will the amount of Refund exceed the amount of benefits paid for the Injury under this Policy.

The right of Refund also applies when the Covered Person recovers under an uninsured or underinsured motorist plan.

"Recovery" means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

"Net Recovery" means the Covered Person's Recovery less attorney's fees and court costs incurred in making the Recovery.

"Refund" means repayment to Us for benefits paid.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT/CHANGES: This Policy and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company.

Any statement made by the policyholder or by a Covered Person shall in the absence of fraud be deemed a representation and not a warranty, and no such statements shall be used in defense to a claim under the Policy and this Certificate, unless contained in a written application.

Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

Such person, his beneficiary or assignee shall have the right to make a written request to Us for a copy of such application, and We shall within 15 days after the receipt of such request at Our principal office or any branch office, deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed, We shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy in conflict on its effective date with the laws of the State of Issue indicated on the front page of this Policy is amended to conform to the minimum requirements of such laws.

DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner;
 - b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
 - c) a Covered Person's parents, whether natural, step or adoptive; otherwise.
- 4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under this Policy.

LEGAL ACTION: All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, Deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, Deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

REPLACEMENT COVERAGE FROM PRIOR CARRIER: If the group policy replaces the group policy of another insurer the prior insurer shall remain liable only to the extent of its accrued liabilities, extension of benefits, and for persons who are under continued group health insurance coverage at the time the group policy terminates.

Our liability will be as follows:

- (a) Each Covered Person who is eligible for coverage shall be covered by our plan on the effective date of coverage.
- (b) When applying any deductibles or waiting periods in our plan, we shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior group policy. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior insurer's group policy during the ninety (90) days preceding the effective date of the group policy, but only to the extent these expenses are recognized under the terms of the new group policy and are subject to similar deductible provisions.
- (c) If a determination of the prior insurer's benefit is required by Us, at our request the prior insurer shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by Us. Benefits of the prior insurer's group policy shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior insurer's group policy rather than those of this group policy. The benefit determination shall be made as if coverage had not been replaced by Us.

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

WORKERS' COMPENSATION: This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Berkley Life and Health Insurance Company

Urbandale, Iowa
Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690



Economic Sanctions Endorsement

This Endorsement attaches to and is made part of Policy Number PAI L106020260201 issued to PHS Football Parent Booster Inc..

This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

U.S. ECONOMIC AND TRADE SANCTIONS CLAUSE

Whenever coverage provided by this Policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to or referred to in any certificates or other evidences of insurance or any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF ENDORSEMENT: 09/26/2022

Signed for the Company:

President

Secretary

BERKLEY LIFE AND HEALTH INSURANCE COMPANY

PRIVACY NOTICE

Berkley Life and Health Insurance Company (the "Company"), a member company of the W. R. Berkley Corporation ("Berkley") group of companies and each other member of the Berkley group of companies ("Affiliates") understands our customers' concern about privacy of their information collected by the Company. Our Company is dedicated to protecting the confidentiality and security of nonpublic personal information we collect about our customers in accordance with applicable laws and regulations. This notice refers to the Company by using the terms "us," "we," or "our." The law requires that we send you a notice describing our privacy policy and how we treat the nonpublic personal information about our customers that we receive in connection with our business (Information").

Why We Collect and How We Use Information.

We collect and use Information for business purposes with respect to our insurance products and services and other business relations involving our customers. We gather this Information to evaluate your request for insurance, to evaluate your insurance claims, to administer, maintain or review your insurance policy, and to process your insurance transactions. We also accumulate certain information about you as may be required or permitted by law.

Your insurance agent or broker also collects this Information and may use it to help with your overall insurance program or to market additional products and services to you. We may also use Information to offer you other products or services that we or our Affiliates provide.

How We Collect Information.

Most Information collected by us is provided by you or your insurance agent or broker to us. We obtain Information from (i) applications or other forms submitted by you, your insurance agent or broker or your authorized representatives to us and our Affiliates, and (ii) your transactions with us or our Affiliates. We may also obtain Information from other sources such as (i) consumer reporting agencies, (ii) other institutions or information services providers, (iii) employers, (iv) other insurers, or (v) your family members.

Information We Disclose.

We disclose any Information which we believe is necessary to conduct our business as permitted by applicable law or where required by applicable law. This disclosure may include (i) Information we receive from you on applications or other forms provided to us and our Affiliates, such as names, addresses, social security numbers, assets, employer information, salaries, etc. (ii) Information about your transactions with us and our Affiliates, such as policy coverages, premiums, payment history, etc., and (iii) Information we receive from a consumer reporting agency, such as credit worthiness and credit history.

To Whom We Disclose Information.

We may, as permitted or required by applicable law, disclose your Information to nonaffiliated third parties, such as (i) your Insurance agent or broker, (ii) independent claims adjusters, (iii) insurance support organizations, (iv) processing companies, (v) actuarial organizations, (vi) law firms, (vii) other insurance companies involved in an insurance transaction with you, (viii) law enforcement, regulatory, or governmental agencies, (ix) courts or parties therein pursuant to a subpoena or court order, (x) businesses with whom we have a marketing agreement, or (xi) our Affiliates.

We may share Information with our Affiliates so that they may offer you products and services from the Berkley group of companies or to analyze our book of business and to consolidate necessary information. We do not disclose Information to other companies or organizations not affiliated with us for the purpose of using Information to sell their products or services to you. For example, we do not sell your name to unaffiliated mail order or direct marketing companies.

How We Protect Information.

We require our employees to protect the confidentiality of Information as required by applicable law. Access to Information by our employees is limited to administering, offering, servicing, processing or maintaining of our products and services. We also maintain physical, electronic and procedural safeguards designed to protect Information. When we share or provide Information to other persons or organizations, we contractually obligate them, if required by law, to treat Information as confidential and conform to our privacy policy and applicable laws and regulations.

Correction and Access to Information.

Upon our receipt of your written request to us at Berkley Life and Health Insurance Company, 475 Steamboat Road, Greenwich, Connecticut 06836-2519 we will, generally, make available Information for your review. If you believe the Information we have about you is incorrect or inaccurate, you may request that we make any necessary corrections, additions or deletions. If we agree with your belief, we will correct our records if required by applicable law. If we do not agree, you may submit to us a short statement of dispute, which we will include in any future disclosure by us of such Information if required by applicable law.

Requirements for Privacy Notice.

This privacy notice is being provided due to recently enacted federal and state laws and regulations establishing new privacy standards and requires us to provide this privacy policy. For additional information regarding our privacy policy, please write to us at 475 Steamboat Road, Greenwich, Connecticut 06836-2519.

Revised: February 7, 2006



PO Box 819
Appleton, WI 54912-0819
(920) 739-3161

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Common Policy
DECLARATIONS

POLICY NO. 20-CP-003374379-0

ACCOUNT NUMBER: 5002784

NAMED INSURED AND MAILING ADDRESS

PHS FOOTBALL PARENT BOOSTER INC
PO BOX 1476
PRESTONSBURG, KY 41653

AGENCY AND MAILING ADDRESS

160117

HALL & CLARK INS AGY
132 S LAKE DR #101
PRESTONSBURG, KY 41653

(606) 886-2318

POLICY PERIOD: FROM 09/26/2022 TO 09/26/2023 AT 12:01 AM STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE.

THE NAMED INSURED IS: Corporation

BUSINESS DESCRIPTION: Clubs - civic, service or social - NO buildings or premises owned or leased except for office purposes - Not-For-Profit only

PROGRAM: Civic, Social, and Fraternal Associations

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

THIS POLICY CONSISTS OF THE COVERAGE PARTS FOR WHICH A PREMIUM IS INDICATED. THIS PREMIUM MAY BE SUBJECT TO ADJUSTMENT

	PREMIUM
COMMERCIAL PROPERTY	\$ Not Covered
COMMERCIAL GENERAL LIABILITY	\$ 656
COMMERCIAL CRIME AND FIDELITY	\$ Not Covered
COMMERCIAL INLAND MARINE	\$ 100
EMPLOYMENT PRACTICES LIABILITY	\$ Not Covered
CYBER SECURITY	\$ 264
ESTIMATED POLICY PREMIUM	\$ 1,020
ESTIMATED POLICY TOTAL	\$ 1,020.00

This is not a bill - Invoice to follow.

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Common Policy
DECLARATIONS

POLICY NO. 20-CP-003374379-0
INSURED: PHS FOOTBALL PARENT BOOSTER INC

EFFECTIVE DATE: 09/26/2022
AGENCY: HALL & CLARK INS AGY

FORMS AND ENDORSEMENTS APPLICABLE TO ALL COVERAGE PARTS

See Forms Schedule

NOTE: IF NO ENTRY APPEARS ON THE ABOVE ENDORSEMENTS, INFORMATION REQUIRED TO COMPLETE THE FORM WILL BE SHOWN ON THE SUPPLEMENTAL FORM DECLARATION IMMEDIATELY FOLLOWING THE APPLICABLE ENDORSEMENT.

THESE DECLARATIONS, IF APPLICABLE, TOGETHER WITH THE COMMON POLICY CONDITIONS, COVERAGE FORM(S) AND ENDORSEMENTS, AND SUPPLEMENTAL FORM DECLARATION(S), IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THE ABOVE NUMBERED POLICY.



PO Box 819
Appleton, WI 54912-0819
(920) 739-3161

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Commercial General Liability Coverage Part
DECLARATIONS

POLICY NO. 20-CP-003374379-0

ACCOUNT NUMBER: 5002784

NAMED INSURED AND MAILING ADDRESS

PHS FOOTBALL PARENT BOOSTER INC
PO BOX 1476
PRESTONSBURG, KY 41653

AGENCY AND MAILING ADDRESS 160117

HALL & CLARK INS AGY
132 S LAKE DR #101
PRESTONSBURG, KY 41653

(606) 886-2318

POLICY PERIOD: FROM 09/26/2022 TO 09/26/2023 AT 12:01 AM STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE.

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

COMMERCIAL GENERAL LIABILITY COVERAGE

LIMITS OF INSURANCE		
GENERAL AGGREGATE LIMIT	\$2,000,000	
PRODUCTS - COMPLETED OPERATIONS AGGREGATE LIMIT	\$2,000,000	
PERSONAL INJURY & ADVERTISING INJURY LIMIT	\$1,000,000	
EACH OCCURRENCE LIMIT	\$1,000,000	
DAMAGE TO PREMISES RENTED TO YOU LIMIT	\$100,000	ANY ONE PREMISES
MEDICAL EXPENSE LIMIT	EXCLUDED	ANY ONE PERSON

ALL PREMISES YOU OWN, RENT OR OCCUPY:

LOC	ADDRESS
1	825 Blackcat Blvd, Prestonsburg, KY 41653

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Commercial General Liability Coverage Part
DECLARATIONS

POLICY NO. 20-CP-003374379-0
INSURED: PHS FOOTBALL PARENT BOOSTER INC

EFFECTIVE DATE: 09/26/2022
AGENCY: HALL & CLARK INS AGY

STATE: KY

CLASSIFICATION							
LOC	CLASSIFICATION	CODE	PREMIUM BASIS	EXPOSURE	PMS RATE	PDTS RATE	OTHER RATE
1	Restaurants - with no sale of alcoholic beverages - without seating	16902	Gross Sales	2,000	3.105	.146	
1	Athletic Leagues, Teams, or Tournaments - Grade 3	20008	Each	40	4.808	Included	
1	Day Camps - Sports	20019	Other	100	0.624	Included	
1	Clubs - civic, service or social - no buildings or premises owned or leased except for office purposes (Not-For-Profit)	41670	Number of Members	25	1.674	Included	

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Commercial General Liability Coverage Part
 DECLARATIONS

POLICY NO. 20-CP-003374379-0
INSURED: PHS FOOTBALL PARENT BOOSTER INC

EFFECTIVE DATE: 09/26/2022
AGENCY: HALL & CLARK INS AGY

POLICY OPTIONAL COVERAGES		
COVERAGE	LIMIT	FORM
General Liability Wrap	View Form	CGT 1000
Hired Auto and Non-Owned Liability	View Form	CGE 0404
Employment- Related Practices Exclusion	View Form	CG2147
Amendment of Insured Contract Definition	View Form	CG2426
Exclusion Fungi or Bacteria	View Form	CG2167
Communicable Disease Exclusion	View Form	CG2132
Additional Insured - Club Members	View Form	CG2002
Professional Liability Coverage		SGE 2010
Professional Liability Fitness and Recreational Facility Schedule	View Form	SGE 2002
Abuse and Molestation	View Form	SGE 2015
Exclusion Amusement Devices	View Form	SGE 2106
Exclusion Fireworks	View Form	SGE 2105
Exclusion Trampolines	View Form	SGE 2107
Excess Provision	View Form	SGE 2401
Abuse Or Molestation Exclusion	View Form	CG2146
Exclusion - Coverage C - Medical Payments	View Form	CG2135

TERRORISM COVERAGE IS ACCEPTED

ANNUAL CHARGE IS \$

5

PREMIUM		
	COMMERCIAL GENERAL LIABILITY ADVANCE PREMIUM	\$ 656

FORMS AND ENDORSEMENTS

APPLYING TO THIS COVERAGE PART AND MADE PART OF THIS POLICY AT TIME OF ISSUE:

See Forms Schedule

NOTE: IF NO ENTRY APPEARS ON THE ABOVE ENDORSEMENTS, INFORMATION REQUIRED TO COMPLETE THE FORM WILL BE SHOWN ON THE SUPPLEMENTAL FORM DECLARATION IMMEDIATELY FOLLOWING THE APPLICABLE ENDORSEMENT.

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Commercial General Liability Coverage Part
DECLARATIONS

POLICY NO. 20-CP-003374379-0
INSURED: PHS FOOTBALL PARENT BOOSTER INC

EFFECTIVE DATE: 09/26/2022
AGENCY: HALL & CLARK INS AGY

THESE DECLARATIONS AND THE COMMON POLICY DECLARATIONS, IF APPLICABLE, TOGETHER WITH THE COMMON POLICY CONDITIONS, COVERAGE FORM(S) AND ENDORSEMENTS, AND SUPPLEMENTAL FORM DECLARATION(S), IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THE ABOVE NUMBERED POLICY.



PO Box 819
Appleton, WI 54912-0819
(920) 739-3161

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Commercial Inland Marine Coverage Part
DECLARATIONS

POLICY NO: 20-CP-003374379-0

ACCOUNT NUMBER: 5002784

NAMED INSURED AND MAILING ADDRESS

PHS FOOTBALL PARENT BOOSTER INC
PO BOX 1476
PRESTONSBURG, KY 41653

AGENCY AND MAILING ADDRESS

160117

HALL & CLARK INS AGY
132 S LAKE DR #101
PRESTONSBURG, KY 41653

(606) 886-2318

POLICY PERIOD: FROM 09/26/2022 TO 09/26/2023 AT 12:01 AM STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE.

SCHEDULED PROPERTY

COVERAGE	LIMIT	FORM
Schedule of Coverages - Scheduled Property Floater	View Form	IM7506

TOTAL SCHEDULED PROPERTY FLOATER PREMIUM	\$	85
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TERRORISM COVERAGE IS ACCEPTED

ANNUAL CHARGE IS \$

2

PREMIUM
COMMERCIAL INLAND MARINE PREMIUM
\$ 100

FORMS AND ENDORSEMENTS

APPLYING TO COMMERCIAL INLAND MARINE COVERAGE PART AND MADE PART OF THIS POLICY AT TIME OF ISSUE:

See Forms Schedule

NOTE: IF NO ENTRY APPEARS ON THE ABOVE ENDORSEMENTS, INFORMATION REQUIRED TO COMPLETE THE FORM WILL BE SHOWN ON THE SUPPLEMENTAL FORM DECLARATION IMMEDIATELY FOLLOWING THE APPLICABLE ENDORSEMENT.

THESE DECLARATIONS, IF APPLICABLE, TOGETHER WITH THE COMMON POLICY CONDITIONS, COVERAGE FORM(S) AND ENDORSEMENTS, AND SUPPLEMENTAL FORM DECLARATION(S), IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THE ABOVE NUMBERED POLICY

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10-03-22

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Page 1 of 1



PO Box 819
Appleton, WI 54912-0819
(920) 739-3161

SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Cyber Security Coverage Part
DECLARATIONS

POLICY NO. 20-CP-003374379-0

ACCOUNT NUMBER: 5002784

NAMED INSURED AND MAILING ADDRESS

PHS FOOTBALL PARENT BOOSTER INC
PO BOX 1476
PRESTONSBURG, KY 41653

AGENCY AND MAILING ADDRESS

160117

HALL & CLARK INS AGY
132 S LAKE DR #101
PRESTONSBURG, KY 41653

(606) 886-2318

POLICY PERIOD: FROM 09/26/2022 TO 09/26/2023 AT 12:01 AM STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE.

THE NAMED INSURED IS: Corporation

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

CYBER SECURITY COVERAGE PART – Cyber Suite

LIMITS OF INSURANCE

First Party Annual Aggregate Limit	\$	50,000
Third Party Annual Aggregate Limit	\$	50,000
Cyber Security Deductible – Per Occurrence	\$	1,000

THIS INSURANCE PROVIDES SOME CLAIMS-MADE COVERAGE. DEFENSE COSTS APPLY AGAINST THE LIMITS OF INSURANCE AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THE ENTIRE FORM CAREFULLY.

FIRST PARTY COVERAGES

DATA COMPROMISE RESPONSE EXPENSES	Included
Sublimits Per Occurrence	
Public Relations	\$ 10,000
Reputational Harm	\$ 10,000
COMPUTER ATTACK	Included
Sublimit Per Occurrence	
Public Relations	\$ 10,000
CYBER EXTORTION	Included
Sublimit Per Occurrence	\$ 10,000
MISDIRECTED PAYMENT FRAUD	Included
Sublimit Per Occurrence	\$ 10,000
COMPUTER FRAUD	Included

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SECURA Insurance Company
COMMERCIAL PROTECTION POLICY
Cyber Security Coverage Part
DECLARATIONS

POLICY NO. 20-CP-003374379-0 INSURED: PHS FOOTBALL PARENT BOOSTER INC	EFFECTIVE DATE: 09/26/2022 AGENT: HALL & CLARK INS AGY
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Sublimit Per Occurrence	\$ 10,000
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TELECOMMUNICATIONS FRAUD Sublimit Per Occurrence	Included \$ 10,000
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REWARD PAYMENTS Sublimit Per Policy	Included \$ 25,000
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THIRD PARTY COVERAGES	
PRIVACY INCIDENT LIABILITY	Included
NETWORK SECURITY LIABILITY	Included
ELECTRONIC MEDIA LIABILITY	Included

IDENTITY RECOVERY COVERAGES	
Annual Aggregate Limit – Per "Identity Recovery Insured"	\$ 25,000
Deductible Per Occurrence – NONE	
Sublimits Per Occurrence	
Lost Wages and Child and Elder Care Expenses	\$ 5,000
Mental Health Counseling	\$ 1,000
Miscellaneous Unnamed Costs	\$ 1,000

TERRORISM COVERAGE IS ACCEPTED.

ANNUAL CHARGE IS INCLUDED

PREMIUM	
CYBER SECURITY COVERAGE PART PREMIUM	\$ 264

FORMS AND ENDORSEMENTS
APPLYING TO THIS COVERAGE PART AND MADE PART OF THIS POLICY AT TIME OF ISSUE:
 See Forms Schedule
NOTE: IF NO ENTRY APPEARS ON THE ABOVE ENDORSEMENTS, INFORMATION REQUIRED TO COMPLETE THE FORM WILL BE SHOWN ON THE SUPPLEMENTAL FORM DECLARATION IMMEDIATELY FOLLOWING THE APPLICABLE ENDORSEMENT.

THESE DECLARATIONS AND THE COMMON POLICY DECLARATIONS, IF APPLICABLE, TOGETHER WITH THE COMMON POLICY CONDITIONS, COVERAGE FORM(S) AND ENDORSEMENTS, AND SUPPLEMENTAL FORM DECLARATION(S), IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THE ABOVE NUMBERED POLICY.



PO Box 819
Appleton, WI 54912-0819
(920) 739-3161

COMMERCIAL LINES INSURANCE PROVISIONS

This information page with "Policy Provisions" completes the below numbered

Company: **SECURA Insurance Company**

Policy Number: 00-00-000000000-0

Account Number: 000000000

