



Dear Parent:

Our school district provides accident coverage for all students. Outlined below is important information regarding this coverage. It is intended as a brief description for reference only, and is not the policy.

Only **ACCIDENTS** that occur in school-sponsored and supervised activities **INCLUDING** participants in interscholastic sports are covered.

DEFINITION OF ACCIDENT:

An unexpected, sudden and definable event which is the direct cause of a bodily injury, independent of any illness, prior injury or congenital predisposition.

Conditions that result from participating in an activity do not necessarily constitute accidents. For example, illnesses, diseases, degeneration, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated by an accident are not covered.

A. This plan of insurance is **EXCESS ONLY**: It will not duplicate benefits paid or payable by any other insurance or plan including HMO's or PPO's.

B. The policy will not cover expenses payable under the insured's HMO (Health Maintenance Organization), or PPO (Preferred Provider Organization). If the insured chooses not to use an authorized medical vendor (under HMO or PPO), the policy will only cover expenses incurred that it would have honored had the insured used the proper medical vendor.

C. Medical treatment for a covered accident must begin within 60 days of that accident. Only expenses incurred within 104 weeks are considered. Benefits are determined on the basis of **REASONABLE AND CUSTOMARY** for the geographic location where services are performed.

D. Specific exclusions of the policy include, but are not limited to, sickness, disease, in any form; non-prescription drugs; fighting; and orthotics not prescribed exclusively for rehabilitation (e.g., playing brace, mouth guard).

E. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Accidents must be reported to the school within 20 days.

HOW TO FILE YOUR **ACCIDENT** CLAIM FORM:

1. Complete **ALL** blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, unknown).
2. Attach all **ITEMIZED** bills to date (not balance due statements) for **MEDICAL EXPENSES ONLY**. Subsequent medical bills can be submitted within 90 days after date of treatment.
3. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge must be processed by all other insurances/plans before they can be processed by A-G Specialty Insurance.)
4. If you are employed and no coverage is provided by your employer, **A LETTER OF VERIFICATION FROM YOUR EMPLOYER STATING THAT NO COVERAGE IS PROVIDED MUST BE SUBMITTED.**
5. Submit claim form within 90 days of the accident by:

Uploading all claim forms and documents using the secure upload portal:
agadmin.retool.com/p/secure-file-upload

Direct any questions or customer service inquiries to PSIC@agadm.com

Prairie State Insurance Cooperative / IL



SPECIALTY INSURANCE



A-G Specialty Insurance is the claims administrator for Mutual of Omaha

K-12 STUDENT ACCIDENT CLAIM FORM

Please complete and submit to A-G Specialty Insurance with itemized medical bills **AND primary insurance explanation of benefits.**

Send all claim forms and documents using our secure upload portal: agadmin.retool.com/p/secure-file-upload

For **questions**, please contact A-G Specialty Insurance, LLC:
PSIC@agadm.com

YOUR INFORMATION

First Name: _____ Last Name: _____

Title: _____ School/Organization Name: _____

Email Address: _____ Phone Number: _____

POLICYHOLDER INFORMATION

Policyholder (School): _____

School Address: _____
STREET CITY STATE, ZIP

STUDENT INFORMATION

Student's Name: _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth: _____ Sex: ☐ M ☐ F Social Security #: _____

Student's Phone Number (or Parent's if minor): _____

Student's EMAIL (or Parent's if minor): _____

Student's Home Address: _____
STREET CITY STATE, ZIP

ACCIDENT INFORMATION

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other (Please explain in Nature of Injury section.)

Type of Activity: ☐ Club Sport ☐ Intramural ☐ Interscholastic ☐ Non-Athletic

Activity/Sport (if athletic related): _____ Accident Date: _____

Body Part Injured: _____ Place of Accident: _____

Nature of Injury (Details of what happened.): _____

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No (Attach separate documents if necessary.)

Insurance Company Name: _____

Insurance Company Address: _____
STREET CITY STATE, ZIP

Policy Number: _____ ID#: _____

Is the student eligible for Medicaid or TriCare Benefits? ____ YES ____ NO

If yes, please file for benefits under the Student Accident Plan before submitting expenses to Medicaid or TriCare.



A-G SPECIALTY INSURANCE, LLC

PO Box 21013, Eagan, MN 55121

Ph: (610) 933-0800 Fx: (610) 933-4122 Email: PSIC@agadm.com

A-G SPECIALTY INSURANCE, LLC
On behalf of Mutual of Omaha
P.O. Box 21013 - Eagan, MN 55121 (610) 933-0800
A-G Specialty Insurance is the claims administrator for Mutual of Omaha

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy/Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide A-G Specialty Insurance, LLC (A-G) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to A-G, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent A-G has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that A-G may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of A-G to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to A-G pursuant to this Authorization, the information will remain protected by A-G in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

_____ (Print Please) Name of Patient	_____ Date of Birth
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_____ Signature of Patient	_____ Date
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(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

_____ Signature of Authorized Representative or Next of Kin	_____ Date
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AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Specialty Insurance to the extent for which A-G Specialty Insurance would not have been liable.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

WARNING: New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SCHOOL OFFICIAL SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties

Arkansas and Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California – For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony. Idaho and Indiana: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person, who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison



A-G SPECIALTY INSURANCE, LLC

PO Box 21013, Eagan, MN 55121

Ph: (610) 933-0800 Fx: (610) 933-4122 Email: PSIC@agadm.com



How to File a Claim

To process your claim please submit the following three pieces of information:

1. **The Claim Form:** Enables us to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure all fields are completed on this form and include the policyholders policy number. In addition, the claim form must be signed by a school or event official.
2. **Itemized Bills:** We require a CMS-1500 (HICF) or UB04 form from the medical provider's billing office (they will know what these are). Account statements or "balance due" statements are helpful, but do NOT contain all the information needed to process the charges (this is what you will typically receive in the mail). A CMS-1500 form is common form from a physician, and the UB04 form is a common form from a hospital or facility. These forms will have all of the necessary information A-G Specialty Insurance requires to satisfy the itemized bill requirement for each charge.
3. **Explanation of Benefits:** If the student has other medical insurance, all medical bills must be first submitted to the student's primary health insurance for their determination of eligibility. If the charges are not paid in full by the other medical insurance carrier we will need to see a copy of the "Explanation of Benefits" from that carrier prior to issuing benefits from this office.
4. **What if I already made payments?:** If you have already made payments, you may be reimbursed for covered charges. We will still need the itemized bill and corresponding EOB for each charge, in addition to your proof of payment (receipt, copy of check, etc.). If proof of payment is not submitted prior to processing, payment will be issued directly to the provider, and you will need to contact the provider for reimbursement.

These documents should be sent through our secure portal for submission purposes only:

agadmin.retool.com/p/secure-file-upload

Alternatively they can be mailed or faxed to:

A-G Specialty Insurance, LLC
Claims Department
P.O. Box 21013 Eagan, MN 55121
Phone: (610)-933-0800
Fax: (610)-933-4122
Payor ID# 11370

For claim questions or status updates, please email [**PSIC@agadm.com**](mailto:PSIC@agadm.com)

If you need further information or have any questions, please call 610-933-0800 to speak to one of our highly qualified Customer Service Representatives between the hours of 8:30 a.m. and 6:00 p.m. E.S.T. Monday-Friday



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