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. Medical bills must be submitted to First Agency within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency at 5071 West H Avenue, Kalamazoo, Michigan 49009 or 269/381-6630 or Fax 269/381-3055.

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 First Agency.)

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. Mail claim form within 90 days of the accident to:

Guarantee Trust Life Ins. Co. administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

First Agency
5071 West H Avenue
Kalamazoo, MI 49009
Tel: (269) 381-6630
Fax: (269) 492-0084
www.1stAgency.com

# BLANKET STUDENT & ATHLETIC ACCIDENT PLAN

# PRAIRIE STATE INSURANCE COOPERATIVE

FIRST AGENCY CONTACTS:

| | | |
|---|---|---|
| Agents: | Kyle McWeeney | Tel: 847-378-5933<br>Fax: 269-492-0084<br>Email: Kyle_McWeeney@AJG.com |
| | Joe Block | Tel: 269-775-3729<br>Fax: 269-492-0084<br>Email: Joe_Block@AJG.com |
| Claims Adjustor: | Beth Deuel | Tel: 269-775-3720<br>Fax: 269-381-3055<br>Email: Beth_Deuel@AJG.com |
| Claims Supervisor: | Andi Gallagher | Tel: 269-775-3718<br>Fax: 269-381-3055<br>Email: Andi_Gallagher@AJG.com |

## THINGS TO REMEMBER

Claim forms can be found at https://www.1stagency.com/k12claimforms

- Claims can be submitted on-line or the form can be downloaded and faxed or mailed.
- Keep in mind that this coverage is secondary or excess and claims must be submitted to student's primary insurance first.
- Please remember to:
  - Fill out the claim form in full.
  - Submit the original itemized bill and primary coverage explanation of benefits (EOB's) when submitting bills to First Agency.

Claim Serial Number (for office use only)

Guarantee Trust Life Ins. Co.
administered by
**First Agency**
5071 West H Avenue
Kalamazoo, MI 49009-8501

# ACCIDENT CLAIM FORM

PARENT/GUARDIAN TO COMPLETE
ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name _____ Exact Date of Accident _____

Student's Date of Birth _____

## FATHER

Father's Full Name _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____
Self Employed? ☐ YES ☐ NO

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan _____
Phone Number _____
Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

## MOTHER

Mother's Full Name _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____
Self Employed? ☐ YES ☐ NO

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan _____
Phone Number _____
Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

**AUTHORIZATION - To Permit Use and Disclosure of Health Information, please complete the Authorization form on the following page.**

## SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends PSIC in Cerro Gordo CUSD #100 School District
Student's Full Name (Last, First, MI): _____ Sex: ☐ Male ☐ Female Grade: _____
Student's Home Address: _____
Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM
Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) _____
Where did it occur? _____
Part of body injured: _____ ☐ Right ☐ Left
Activity: _____ ☐ Interscholastic ☐ Intramural ☐ Club ☐ Other (describe) _____
Name of school authority supervising activity: _____
Was supervisor a witness to the accident? ☐ Yes ☐ No If No, date reported to school: _____
Signature of School Official: _____ Date: _____ Title of School Official: _____

First Agency
5071 West H Avenue
Kalamazoo, MI 49009

# 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 #** 124-127-J26

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 First Agency 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 First Agency, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent First Agency 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 First Agency 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 First Agency 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 First Agency pursuant to this Authorization, the information will remain protected by First Agency 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

Signature of Patient — Date

(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