STUDENT ACCIDENT INSURANCE

Diocesan Insurance Office
Diocese of Kansas City-St. Joseph
PO Box 419037
Kansas City, MO 64141-6037

From: Monica Adams, Risk Manager

Date: August 21, 2018

Re: School Time Accident Coverage for August 15, 2018-19

The Diocese of Kansas City-St. Joseph has purchased **School Time Accident Coverage** to protect all students against accidental injury or death occurring while the policy is enforce. The policy period is August 15, 2018-19. The insurance covers for the hours and days when school is in session, and while attending school sponsored and supervised activities. This includes all Interscholastic Sports and Football.

Coverage is underwritten by **Guarantee Trust Life Insurance Company** and administered by **First Agency, Inc.** The premium for this coverage has been included in Insurance Deposit which is billed to your high school, elementary school, preschool, daycare and/or early childhood center.

The coverage consists of two plans:

Basic School Time Accident Plan: The Basic plan covers the usual and reasonable expenses for medical services **incurred within two years of the injury.** It is called Full Excess because it is in excess of another plan providing medical expense benefits. The first expense must be incurred **within 90 days** after the accident.

Catastrophic School Time Accident Plan: The Catastrophic plan provides lifetime coverage up to $2,000,000 after the parents have incurred $25,000 in expenses.

To File a Claim: (Claim forms are enclosed.)

- Instructions for filing a claim are listed on the back of the claim form.
- When a child is injured at school or during a school sponsored activity, a school official completes the lower section of the claim form.
- The claim form is given to the parent/guardian to complete the upper section of the claim form.
- The parents send the completed claim form directly to **First Agency, Inc, 5071 West H Ave, Kalamazoo, MI 49009**.
- ***FORM MUST BE SENT WITHIN 90 DAYS OF THE ACCIDENT TO FIRST AGENCY.***

Please do not hesitate to offer claim forms to the parents. If you have any questions regarding coverage or need additional supplies, please call Monica Adams at (816)756-1850 extension 233 or email adams@diocesekcsj.org.

Please share with your teachers, coaches, and health room staff.

Dear Parent:

Our school 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 52 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, or hernia 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 presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Accidents must be reported to the school within 20 days. Medical bills must be submitted to First Agency, Inc. within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency, Inc. 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, Inc.)

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:

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

Claim Serial Number (for office use only)

First Agency, Inc.
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 Social Security Number _____ 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 _____

Social Security Number _____

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 _____

Social Security Number _____

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

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. 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. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have 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. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. 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. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Authorized Representative, or Next of Ken

Name of Claimant

Signature of Authorized Representative or Next of Kin Date

Signature of Claimant (if claimant is 18 or older) Date

Relationship of Authorized Representative or Next of Kin to Claimant

SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends _____ in Diocese of KansasCity-St.Joseph, MO 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: _____