IMPORTANT REMINDER

To: Principals, Secretaries, Athletic Directors/Secretaries/Trainers

From: Mary Miilu

RE: STUDENT ACCIDENT INSURANCE

Date: August 11, 2015

The beginning of the school year is a great time to review the student insurance policy to make sure everyone has the current information regarding our coverage, and can correctly relay this info to parents. Zeeland Schools is not required to carry student insurance but it is a benefit we feel is important and provide to families at no cost. If you recall, the coverage for students changed in the 2012-13 school year to include a $500 deductible for families, as well as limits on coverage; however, some parents are still being told that our policy will pick up costs in full that their primary insurance does not cover. This is no longer the case, and our policy only covers 50 percent of balances once the $500 deductible is met. This misinformation has prompted phone calls to me from numerous unhappy parents because they were not expecting to have any out of pocket costs. To help clarify this information, please make sure you advise them to read the back of the claim form in full and keep a copy for their records.

When a student accident occurs in your building or at a sporting event, please follow these guidelines:

- Complete the building injury report form and the school district's portion of the First Agency claim form and send a copy of both to me.
- Give the yellow (original) claim form, along with the instruction sheet to the parent/guardian, and stress to them they MUST read the back of the form for a complete explanation of our coverage.
- Make sure they understand it is their responsibility to complete their portion and submit the claim form to First Agency. If they have any questions, they may contact me and I will assist them in any way possible.
- **IMPORTANT – Do not tell the parent/guardian that the school district will take care of the medical bills or that the injury is covered by insurance**. First Agency must make the determination if an accident has occurred. A few of the exclusions include illness, diseases or conditions caused by continued stress that are not accidents and therefore are not covered.

Just to make sure there are no old forms lingering out there stating full coverage, please dispose of any First Agency forms you have in your file and use the attached. Please run copies both sides of the form on yellow paper as necessary as I do not have a supply.

Also, if you would pass this information on to anyone else that may handle a student injury in your office, I would greatly appreciate it. Athletic Directors, please make sure this info is relayed to ALL coaches and trainers. If you have any questions or concerns, feel free to give me a jingle!

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 (please print) _____ 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 _____ Title _____

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 _____ Title _____

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 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 Kin (please print)

_____
Name of Claimant (please print)

_____ _____
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 _____ School District

Student's Full Name (print 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 (please print)

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, subject to the following limitations:

Inpatient/Outpatient Hospital room and board, general nursing care, Hospital Emergency care and Hospital miscellaneous expense limited to a maximum of $3,000 per day.

Doctor`s fees for surgery limited to $3,500 per accident.

Inpatient/Outpatient imaging procedures, including x-rays and interpretation for fracture or dislocation, no fracture or dislocation, and MRI/CAT scan, limited to a maximum of $500 per accident.

Physical Therapy and/or treatment of the spine by manual or mechanical means, limited to a maximum of $500 per accident.

D. A $500 deductible will be applied to each claim regardless of other valid collectible insurance or plan payments.

E. The balance of covered expenses will be processed on a 50% payment basis.

F. 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).

G. 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