# PARENT/GUARDIAN TO COMPLETE

THE FOLLOWING INFORMATION MUST BE PROVIDED OR CLAIM CANNOT BE PROCESSED

**Claim Serial #** _____

_____ _____

Student's Full Name (Please Print) Date Injury Sustained (Exact Date of Accident)

_____

Student's Date of Birth

**FATHER**

Full Name: _____
Home Address: _____
City_____ State_____ Zip Code_____
Home Phone: (_____) _____
Employer Name:_____ Title: _____
Employer Address: _____
City_____ State_____ Zip Code_____

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

| | YES | NO |
|---|---|---|
| Do you have insurance? | [ ] | [ ] |
| Is this student covered? | [ ] | [ ] |

_____ _____
Name of Insurance Plan Social Security Number
(_____)_____ _____
Telephone 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**

Full Name: _____
Home Address: _____
City_____ State_____ Zip Code_____
Home Phone: (_____)_____
Employer Name:_____ Title: _____
Employer Address: _____
City_____ State_____ Zip Code_____

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

| | YES | NO |
|---|---|---|
| Do you have insurance? | [ ] | [ ] |
| Is this student covered? | [ ] | [ ] |

_____ _____
Name of Insurance Plan Social Security Number
(_____)_____ _____
Telephone 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.

**American Fidelity Assurance Company, Oklahoma City, Oklahoma**
**administered by**
**First Agency, 5071 West H Avenue, Kalamazoo, MI 49009-8501**
**AUTHORIZATION - To Permit Use and Disclosure of Health Information**

This Authorization was prepared by First Agency 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 our Administrator, First Agency 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 First Agency at the above address. I understand that a revocation will not be effective to the extent American Fidelity Assurance Company 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. Revocation requests must be sent in writing to the attention of the Claim Department Manager of First Agency.

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. I also understand, once information is disclosed to our Administrator, First Agency pursuant to this Authorization, the information will remain protected by First Agency 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.

_____ _____ _____
(Please Print) Name of Claimant Signature of Claimant if claimant is 18 or older Date

_____ _____
(Please Print) Name of Authorized Representative, or Next of Kin Relationship of Authorized Representative or Next of Kin to Claimant

_____ _____
Signature of Authorized Representative or Next of Kin Date

# SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

SCHOOL STUDENT ATTENDS: _____IN _____SCHOOL DISTRICT
STUDENT'S FULL NAME (PRINT LAST, FIRST, MI): _____SEX:_____ GRADE:_____
STUDENT'S HOME ADDRESS:_____
DATE OF ACCIDENT:_____TIME OF ACCIDENT:_____ AM or 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 [ ] or LEFT [ ]
ACTIVITY: _____ INTERSCHOLASTIC [ ] INTRAMURAL [ ] CLUB [ ]
OTHER (DESCRIBE):_____
NAME OF SCHOOL AUTHORITY SUPERVISING ACTIVITY:_____
WAS SUPERVISOR A WITNESS TO THE ACCIDENT? YES [ ] NO [ ] IF NOT, 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:

A sudden, unforeseeable, external event which results in an Injury.

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. 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. Proof of loss must be submitted to First Agency within 90 days after medical treatment ends. 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 (not balance due statements) for **MEDICAL EXPENSES ONLY**.

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 within 90 days of the accident to:

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

(K-12 Risk Name/State)