michigan high school athletic association

John E. Roberts, Executive Director

1661 Ramblewood Drive • East Lansing, MI 48823-7392 • 517-332-5046 • Fax 517-332-4071 • Web mhsaa.com

L-A/Aug 2016 Memo-Concus

TO: Superintendents of MHSAA Member Schools

FROM: John E. (Jack) Roberts, Executive Director

DATE: August 2016

SUBJECT: **Insurance Benefits**

As you know, MHSAA membership is entirely free of expense to member junior high/middle schools and high schools. There are no membership dues and no MHSAA postseason tournament entry fees.

Among the no-cost-to-schools benefits of MHSAA membership is the Catastrophic Accident Medical Insurance Policy which pays up to $500,000 for medical expenses left unpaid by other insurance after a deductible of $25,000 per claim in paid medical expenses has been met. All students enrolled in grades 6 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is $25,000 for each accident. Covered students, sports and situations follow the catastrophic accident medical insurance.

This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.

Regarding the new program, you will find enclosed . . .

- A sample letter for schools to send to each student-athlete's parents or guardians
- Summary of Coverage
- Instructions on "How to File a Claim"
- Incident Report
- Other Insurance Questionnaire

JER/ky

Enclosures

Electronic Copies to Principals & Athletic Directors

August 2016

Dear Parent/Guardian,

School sports participation, like much of what our children enjoy, has some inherent risk of injury. However, the leadership of interscholastic athletics in this school district and across the state of Michigan is attempting both to provide as safe an experience as possible and enhance the health of our student-athletes.

As a part of these efforts, the Michigan High School Athletic Association provides all of its member schools with a Catastrophic Accident Medical Insurance Policy which pays up to $500,000 for medical expenses left unpaid by other insurance after a deductible of $25,000 per claim in paid medical expenses has been met. All students enrolled in grades 6 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided eligible athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is $25,000 for each accident. Covered students, sports and situations are identical to the catastrophic accident medical insurance which, if the $25,000 threshold is reached, would require a separate claim to be made.

This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.

Should you have need to make a claim under this new program, contact terri.bruner@kandkinsurance.com, or phone 800-237-2917 toll free.

Sincerely,

_____

insuring the world's fun®

Binder Addendum

Proposal to:
Policyholder: Michigan High School Athletic Association
1661 Ramblewood Drive
East Lansing, MI 48823

Coverage Period: 8/01/2016 – 8/01/2017

Carrier: Nationwide Life Insurance Company, AM Best Rated A+ XV

Excess Accident Medical Limits:

Maximum:	$ 25,000 per injury
Usual & Customary	100%
Benefit Period:	1 Year
Deductible:	$0 per claim
AD&SL	$5,000
AD&SL Aggregate	$250,000

Eligible Person:
All students Grades 6-12 who are at a member school of the Policyholder and are participating in a Covered Activity.

Covered Activities:
Participating in practice or play of interscholastic sports under the jurisdiction of the Policyholder. Interscholastic sports include: Baseball, Basketball (boys and girls), Bowling (boys and girls), Cross Country (boys and girls), Football, Golf (boys and girls), Gymnastics (girls), Competitive Cheer (girls), Ice Hockey, Lacrosse (boys and girls), Soccer (boys and girls), Softball (girls), Alpine Skiing (boys and girls), Swimming and Diving (boys and girls), Tennis (boys and girls), Track and Field (boys and girls), Volleyball (girls) and Wrestling.
Includes traveling directly to and from a scheduled event as a representative of the school while traveling in transportation sponsored by the school.
Sideline cheerleaders are covered while traveling directly to and from interscholastic athletic events as a representative of the school while traveling in transportation sponsored by the school, and while cheering at interscholastic athletic events under the direct supervision of a school employee designated by the school.

1712 Magnavox Way, P.O. Box 2338
Fort Wayne, IN 46801-2338
800-637-4757 Fax: 260-459-5866
www.kandkinsurance.com
California License #0334819

How to File a Claim

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

1. Completed and Signed 'K&K Incident Report'
2. Complete and Signed 'Other Insurance Questionnaire'
3. Itemized Bills
4. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed, emailed or faxed to:

K&K Insurance Group
Attn: Terri Bruner
1712 Magnavox Way
Fort Wayne, IN 46801

Terri.Bruner@kandkinsurance.com

(312) 381-9077 Fax
(800) 237-2917 Toll Free

The 'K&K Incident Report' enables the payer to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure to complete the 'Other Insurance Questionnaire'. The incident report must be signed by an MHSAA member school administrator.

Itemized Bills – please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account Statements or 'Balance Due' statements are helpful, but do not contain all the information needed to process the claim.

Explanation of Benefits – If you have other medical insurance, all medical bills first be submitted to that carrier for its determination of eligibility and payment. 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' prior to paying any benefits. If you do not have other insurance, the need for an 'Explanation of Benefits' will not apply to your claim.

d:r
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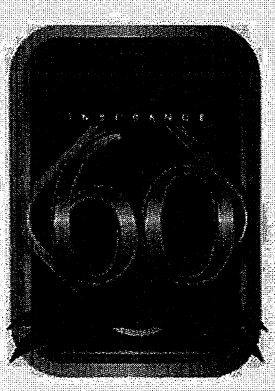

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

Michigan High School Athletic Association
Concussion Coverage

(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ❑ AM ❑ PM
EVENT NAME:_____
EVENT TYPE:_____ CONDUCTED BY:_____
LOCATION:_____

HAPPENED TO
NAME:_____ SSN:_____
DATE OF BIRTH: _____ SEX: ❑ Male ❑ Female PHONE: (____) _____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

FUNCTION
AS: ❑ ATHLETE
❑ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION:_____
❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:_____
❑ AMBULANCE, TAKEN TO:_____ CITY:_____
❑ FATALITY

OCCASION
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?_____

INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED:_____

OTHER SCHOOL INSURANCE
DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? ❑ Yes ❑ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY:_____

INSURED
NAME OF INSURED:_____ POLICY#:_____
CLUB NAME:_____ PHONE: (____) _____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ MHSAA Member School Administrator ❑ OTHER:_____
NAME:_____ PHONE: (____) _____
TITLE:_____ ORGANIZATION:_____
SIGNATURE:_____ DATE:_____

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

K&K INSURANCE

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT:_____ INTERNATIONAL STUDENT ❑ Yes ❑ No

EMANCIPATED STUDENT: ❑ Yes ❑ No

NAME OF INSURED:_____ POLICY NO:_____

FATHER

IS FATHER DECEASED? ❑ Yes ❑ No

IS FATHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

FATHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:____ ZIP:_____

POLICY NUMBER:_____

TYPE OF PLAN:
- ❑ HEALTH MAINTENANCE ORGANIZATION (HMO)
- ❑ PREFERRED PROVIDER ORGANIZATION (PPO)
- ❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ❑ OTHER (describe)_____

MOTHER

IS MOTHER DECEASED? ❑ Yes ❑ No

IS MOTHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

MOTHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:____ ZIP:_____

POLICY NUMBER:_____

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- ❑ PREFERRED PROVIDER ORGANIZATION (PPO)
- ❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ❑ OTHER (describe)_____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE:_____ PARENT/GUARDIAN/MOTHER SIGNATURE:_____

DATE:_____ DATE:_____