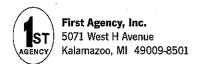
Claim Serial Number (for office use only)



ACCIDENT CLAIM FORM

PARENT/GUARDIAN TO COMPLETE

ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name (please print) Student's Social Security Number				
Father's Full Name				
Home Address				
City State Zip			State	
Home Phone ()	·)	
Employer Name Title			Title	
Employer Address				
CityStateZip			State	
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS AR			LLOWING SECTION EVEN IF NO B	
Do you have insurance? YES NO	E PROVIDED.	Do you have insurance?	YES NO	ENEFITS ARE PROVIDED.
Is this student covered? Types No		Is this student covered?	☐ YES ☐ NO	•
Name of Insurance Plan				
Social Security Number				
Phone Number () Group Number) Group	
	_			
If you are employed, but your dependent is not covered under you plan, a letter to this effect from your employer is required.	ır employer's		your dependent is not covered of from your employer is requi	
AUTHORIZATION - To Permit Use and Disclos This Authorization was prepared by First Agency, Inc. for purposes of o			n for benefits.	First Agency, Inc. 5071 West H Avenue Kalamazoo, MI 49009-85
professional, hospital or other medical-care institution, insurance supp plan administrator to provide First Agency, Inc. or an agent, attorney, of care or treatment provided the patient, employee or deceased named be includes information provided to our health division for underwriting of Authorization is for someone other than myself, that individual has give I understand that I have the right to revoke this Authorization, in writing	consumer reporting ag pelow, including all inf r claim servicing and en me authority to act	gency or independent admin ormation relating to, mental information provided to any on his/her behalf as explain	istrator, acting on its behalf, all illness, use of drugs or use of a affiliated insurance company of aed below.	information concerning advict alcohol. This Authorization also in previous applications. If th
revocation will not be effective to the extent we have relied on the use only eligibility for benefits. Revocation requests must be sent in writing	or disclosure of the pr	otected health information o		
I understand that First Agency, Inc. may condition payment of a claim of the claim payment. I also understand, once information is disclosed with federal or state law.				
understand that I or my authorized representative is entitled to receive	e a copy of this autho	rization upon request.		
This Authorization is valid from the date signed for the duration of the o	claim.	Name of Authorized Penn	esentative, or Next of Kin (please pri	nt)
		Hame of Authorized Repr	esentative, or Next of Mil (please pri	щ
lame of Claimant (please print)		Company of Authorized D	any and at the ar New of Vin	Data
ranie of Gramman (please print)		Signature of Authorized K	epresentative or Next of Kin	Date
Signature of Claimant (if claimant is 18 or older) Date		Relationship of Authorized	i Representative or Next of Kin to Cl	aimant
SCHOOL / ADMINIST	RATOR/OFFICIA	AL/POLICYHOLDER	TO COMPLETE	Broth Marian management
School Student Attends:		in		School Distric
Student's Full Name (print Last, First, MI):			Sex: Male Female	Grade:
itudent's Home Address:		·		
Date of Accident: Time of Acc		□ AM □ PM		
Detailed Description of Accident: How did it occur? (or attach accident	<u></u>		witnessed the accident)	
Where did it occur?				
Part of body injured:			☐ Right ☐ Left	
Activity:	☐ Interscholastic	☐ Intramural ☐ Clu	b Other (describe):	
Name of school authority supervising activity:				
Was supervisor a witness to the accident? \square Yes \square No \square If No	o, date reported to sch	ool:		
The state of the s				

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 <u>ACCIDENTS</u> 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 <u>REASONABLE AND CUSTOMARY</u> 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. Proof of loss must be submitted to First Agency, Inc. within 90 days after medical treatment ends. 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 (not balance due statements) for MEDICAL EXPENSES ONLY.
- 3. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge <u>must</u> 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 within 90 days of the accident to:

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