Claim Serial Number (for office use only)

Guarantee Trust Life Ins. Co.
administered by
First Agency
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 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 _____
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 _____
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
5071 West H Avenue
Kalamazoo, MI 49009-8501

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 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 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 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 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

_____
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 _____ 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: _____

Dear Parent or Guardian:

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, or disease, 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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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:** **Guarantee Trust Life Ins. Co. administered by**
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501