FORT THOMAS
INDEPENDENT SCHOOLS

July 1, 2013

To whom it may concern:

We are sorry that your son or daughter was recently injured during a school activity. The purpose of this packet is to educate you about the Student Accident Insurance coverage that Fort Thomas Independent Schools maintains on all of our students during the school year. It is our intent to make sure that you have as much information regarding this insurance as possible and to insure that you have all the necessary forms required to initiate a claim and submit the items for payment. The Student Accident Insurance maintained by the District is supplemental insurance, but it can be primary insurance if the student is not covered by any other insurance policy. The District has obtained coverage from a new carrier this year. The new company is Scholastic Insurors, Inc. The filing of claims and the benefit levels are different than in past years. Please read the attached information carefully.

Included in this packet is the following information:

1) Instructions for filing a claim
2) Claim Form
3) Policy benefit information & limitations

Our local representative for this policy is Crawford Insurance. If, at any point in this process, you have questions regarding your claim or this process, please contact Tammy at Crawford Insurance for assistance. Tammy can be reached at 859-581-2088 or via email at tammy_roberts@crawfordins.com

Sincerely,

Jerry Wissman

Jerry Wissman
Director of Operations
Fort Thomas Independent Schools

28 NORTH FORT THOMAS AVENUE | FORT THOMAS, KENTUCKY 41075-1555
859.781.3333 ph | 859.442.4016 fx | WWW.FORTTHOMAS.KYSCHOOLS.US

IMPORTANT INFORMATION PLEASE READ

THIS IS A NEW INSURANCE CARRIER AND CLAIM PROCESSING IS DIFFERENT THAN IN PAST YEARS

- It is not necessary to notify Scholastic Insurors, Inc. at the time of injury. No claim will be processed until the below information is submitted for payment.
- When a student is first injured, school staff will provide the family with a copy of this information packet. It is the responsibility of the family to complete Part B of the claim form and return to the school office within five days of the injury. The school will complete Part A of the claim form, sign where appropriate and return to the family for processing. At that time the PARENT is responsible for submitting the claim form along with the information below:

    - Along with the signed and completed claim form an Itemized Bill from the provider (UB-04 form for hospital charges and CMS-1500 form for physician charges.)
    - A copy of an Explanation of Benefits (EOB) from your primary insurance carrier. This is the statement received from the insurance carrier that indicates payment made and any patient responsibility.
    - If there is no primary insurance, a written statement from the insured's parent's employer verifying there is no coverage will need to be attached.
    - You also have the option to select if you want payment to be mailed to you or a provider. It is important to indicate this on the claim form by checking question #2 directly above the signature section on the claim form.

- Once this above documentation is complete, it is the PARENT'S responsibility to file the claim with Scholastic Insurors, Inc. via fax, email or mail.
- Failure to submit all of the above information will result in a denial or delay in payment.
- Because you may have multiple claims for this injury it is very important that you make copies of this claim form for any future claim submissions on this claim.

If at any time you have questions please contact our local representative Tammy Roberts at Crawford Insurance at 859-581-2088 or via email at tammy_roberts@crawfordins.com

Please Read Before Submitting a Claim

Instructions for Filling out a Claim Form

Important!!!!!

- Treatment Must Begin Within 30 Days from Date of Accident
- Completed Claim Form Must be Submitted Within One (1) Year From Date of Accident
- All Treatment Must be Received Within One (1) Year of Accident
- Since this policy is secondary to any primary insurance, all claims must be submitted to the primary insurance first.

WHEN TO FILE A CLAIM WITH SCHOLASTIC INSURORS:

- Once you have received an Explanation of Benefits (EOB) from your primary insurance as well as an Itemized Statement provider (UB-04) for hospital charges and CMS-1500 form for physician charges.
- The completed claim form and supporting documentation must be received by Scholastic Insurors within one (1) year after the date of the accident.

COMPLETING THE CLAIM FORM:

- Part A & B must be completed in full.
- In the event the claimant sustained a dental injury, Part C must be completed in full by the dentist providing treatment.
- Indicate on question #2 directly above the signature line, if you want payment to be sent directly to you or the provider. If this is not marked, payment will be made directly to you.
- Attach an itemized statement from the provider. This is NOT a bill from the provider but a (UB-04 form for hospital charges and CMS-1500 form for physician charges. You will need to request this from the provider.
- Attach a copy of the Explanation of Benefits (EOB) that you received from your primary insurance indicating the payment the primary insurance has made to the provider. You will receive this from your insurance carrier after the claim has been processed by the primary insurance.
- If an insured has no primary coverage, please contact our local representative Crawford Insurance, Tammy Roberts at 859-581-2088 for additional assistance.

WHERE TO FILE A CLAIM:

Send all completed forms, itemized bill and explanation of benefits to:

Mail: Scholastic Insurors, Inc.
P. O. Box 3194
Johnson City, TN 37602-3194

Fax: 423-928-2761

Email: johnj@scholasticinsurors.com

If any time during this process you need assistance please contact our local representative Crawford Insurance at 859-581-2088 or tammy_roberts@crawfordins.com

*The insured shall have free choice of a physician or hospital for treatment. HOWEVER, if an insured has other valid coverage through another insurance plan(s) and does not choose a physician or hospital that participates with the other plan, we will pay benefits as if the other plan's guidelines have been followed.

AS-00

SCHOLASTIC INSURORS, INC.
P. O. Box 3194, Johnson City, TN 37602-3194

GROUP ALL SCHOOL INSURANCE CLAIM FORM

PLEASE READ CAREFULLY

PART A
SCHOOL OFFICIAL TO COMPLETE

1) Name of School _____ Name of School System Ft. Thomas Independent Schools
School Address Ft. Thomas (City) Ky (State) 41075 (Zip)
2. Name of Injured Student (Print) _____ (First) (Middle) (Last) Grade ____ Age ____
3. Date of Injury _____ Time of Injury _____
4. Under whose supervision? _____ Title _____
5. The accident was incurred while the student was participating in:
(check one) _____ Game _____ Practice _____ P.E. _____ Travel _____ Other
6. At the time of the injury, was the student involved in a school sponsored and supervised activity? ____ yes ____ no
7. Describe the accident fully. How did the accident happen?

_____

_____

Reported by: _____
(Signature of School Official) (Title) (Date)

PART B: PARENT/GUARDIAN STATEMENT

FATHER or GUARDIAN

Full Name _____ S.S.# _____
Address _____ (street)
_____ (city) (state) (zip)
Occupation _____ Employer _____
Employer Address _____ (street)
_____ (city) (state) (zip)
Name & Address of Other Insurance Company _____
_____
Policy/Group No. _____
Group Individual HMO/PPO

MOTHER or GUARDIAN

Full Name _____ S.S.# _____
Address _____ (street)
_____ (city) (state) (zip)
Occupation _____ Employer _____
Employer Address _____ (street)
_____ (city) (state) (zip)
Name & Address of Other Insurance Company _____
_____
Policy/Group No. _____
Group Individual HMO/PPO

KENTUCKY REQUIRED STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

1. **I understand that I must furnish, with this claim, a statement from my personal insurance company indicating their allowable benefits or their reason for refusal to pay. I further understand this claim will remain pending until this information is provided.**
2. I hereby authorize Reliance Standard Life Insurance Company to pay benefits (as provided by the policy) in connection with this accident direct to the doctor , and/or hospital rendering service unless I have checked below.
_____ I do not authorize an assignment and request that benefits be paid directly to me.
3. I hereby authorize any insurance company, hospital, physician. or other person who has attended or examined the claimant to disclose when requested to do so by Reliance Standard Life Insurance Company, or its representative, any and all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.
4. I understand that I shall have a free choice of a physician or hospital for treatment. If, however, there is other valid coverage through another insurance plan and I do not choose a physician or hospital through the other plan, Reliance Standard Life will pay benefits as if the other plan's guidelines had been followed.
5. I certify that I have read and understand items 1-- 4 (above) and I have read and understand the information on the reverse side of this form.

_____ (Date) _____ (Signature of Parent or Guardian)

PART C: FOR DENTAL INJURY

To be completed by dentist in the event of injury involving treatment to one or more teeth. Not to be used as a replacement for a copy of the actual itemized charges.

1. Identify injured teeth by tooth No. _____

Ft. Thomas Independent Schools

MEDICAL AND DENTAL EXPENSE BENEFITS

For

All School Plan – *Basic Coverage*

2013-14

MAXIMUM MEDICAL BENEFITS.....$25,000

PHYSICIAN'S BENEFITS

Surgery Fees ($3,000 per injury limit).....R.N.*

Non-surgical visits, consultations, or interpretations ($35 per visit)...R.N.

HOSPITAL BENEFITS

Daily room and board charge (Semi-Private Room).....R.N.

Miscellaneous in-patient and out-patient surgery expenses including operating room, lab, x-ray, therapy, supplies, drugs, etc. ($2,000 per injury limit).....R.N.

Emergency room expenses ($500 per injury limit).....R.N.

DIAGNOSTIC X-RAY/RADIOLOGICAL/IMAGING/MRI/CAT SCAN BENEFITS

Out-patient service or at doctor's office including reading fees ($400 per injury limit).....R.N.

OUT-PATIENT PHYSICAL THERAPY VISITS BENEFIT

($35 per visit - 5 visits limit).....R.N.

ORTHOPEDIC APPLIANCE BENEFIT

($100 limit).....R.N.

DRUGSTORE PRESCRIPTIONS BENEFIT

($50 limit).....R.N.

DENTAL BENEFIT

Amount payable for each injured tooth; orthodontics excluded ($200 per tooth limit).....R.N.

AMBULANCE SERVICE BENEFIT

($100 per injury).....R.N.

NOTE:
1. *R.N. is defined as what is reasonable and necessary to treat an injury up to the $25,000 limit.
2. Coverage is *"secondary"* to all other family insurance plans. Family insurance coverage, if any, must be considered first. Certain exclusions apply to these plans.
3. All medical, surgical, and dental treatment must begin within 30 days and be received within one year from the date of original injury.