School Board of Lake County

2023-2024 Secondary (Excess) Student Accident Insurance
Claims Filing Checklist

PLEASE NOTE – THIS POLICY IS SECONDARY TO PARENTAL/GUARDIAN MEDICAL/DENTAL INSURANCE. THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY.

☐ 1. Parent/Guardian – Complete First Agency Accident/Injury Claim Form and return to Lake County Risk Management for signature and submission.

☐ 2. Lake County – Authorized Risk Management Official to review the completed First Agency Accident/ Injury Claim Form and sign the form.

☐ 3. Lake County Risk Management Official will submit completed and signed accident claim form to First Agency. Please retain a copy for your records.

First Agency
5071 West H Avenue
Kalamazoo, MI 49009
Phone: (269) 381-6630
Fax: (269) 381-3055
Email: Charlie_Eisenbies@ajg.com

☐ 4. See Claim Filing Instructions page for additional information regarding the claims process.
   i. Please notify all health care professionals that you have secondary coverage for the accident/injury. You should provide them with a copy of the insurance card and claim filing instructions in this packet and instruct the provider to bill First Agency directly after primary insurance has processed the claim.

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	MOTHER
Father's Full Name ______________	Mother's Full Name ______________
Home Address ______________	Home Address ______________
City ________ State ______ Zip ______	City ________ State ______ Zip ______
Home Phone ______________	Home Phone ______________
Employer Name ______________	Employer Name ______________
Employer Address ______________	Employer Address ______________
City ________ State ______ Zip ______	City ________ State ______ Zip ______
Self Employed? ☐ YES ☐ NO	Self Employed? ☐ YES ☐ NO
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:
Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO	Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan ______________	Name of Insurance Plan ______________
Phone Number ______________	Phone Number ______________
Group 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.	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, please complete the Authorization form on the following page.

RISK MANAGEMENT OFFICIAL 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 Risk Management Official: ______________ Date: ______________ Title of School Official: ______________

First Agency
5071 West H Avenue
Kalamazoo, MI 49009

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy/Certificate # ______________________________

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. 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. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to First Agency, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent First Agency 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.

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. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of First Agency to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to First Agency pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

____

(Print Please) Name of Patient | Date of Birth

____

Signature of Patient | Date

____

(Please Print) Name of Authorized Representative, or Next of Kin

____

Relationship of Authorized Representative or Next of Kin to Patient

____

Signature of Authorized Representative or Next of Kin | Date

2023-2024 Secondary (Excess) Student Accident Insurance
Claims Filing Instructions

The School Board of Lake County has obtained a Secondary (Excess) Student Accident Insurance policy in the event that a student is injured during a sponsored/supervised school time or athletic event and will require outside medical treatment. An Injury Claim form will be submitted on behalf the camper to First Agency, the Claims Company for the accident insurance policy.

Please be advised that this coverage is excess (secondary in most situations) to all other valid and collectable insurance plans. Each student should initially provide their primary health insurance information to each medical provider at the time of treatment, as well as the Secondary (Excess) Student Accident insurance information. This policy is designed to cover any remaining balances of expenses related to a covered injury/accident that are not covered by the student's primary insurance (including co-pays, deductibles, coinsurance, etc.) and left to patient responsibility.

To ensure that claims are covered under the Secondary (Excess) Student Accident Insurance, students are asked to give the billing information to each medical provider prior to every medical treatment and/or service for a School Board of Lake County sponsored/supervised activity or event, related injury. **Please present the Identification Card below.**

Front of Card

Student Accident Insurance Plan
Secondary (Excess) Coverage

School Board of Lake County

Policy Effective Date:	August 1, 2023
Policy End Date:	July 31, 2024
Benefit Period:	2 Years from Date of Injury
Deductible:	$0 per Injury
Coverage limit:	$25,000 per accident

Policy #: 094-020-001F
Group #: SBLC2023

Back of Card

Members Call: 1-269-381-6630
Providers Call: 1-269-381-6630

Eligibility is subject to change. This card is for identification purposes only and does not guarantee benefits.

For claims questions or submissions, please contact

First Agency
5071 West H Avenue
Kalamazoo, MI 49009

Phone: 269-3816630 | Fax: 269-381-3055

Frequently Asked Questions

This is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.

Q. What is “Student Accident Insurance” and why does the School Board have a policy?

A. The School Board obtains Student Accident Medical Insurance to help cover medical expenses related to a covered activity injury that results from a sponsored/supervised camp. The excess policy pays **after** any other valid/collectible insurance that the student carries (i.e. a parent’s employer plan, etc.). The Student Accident Insurance is designed to cover expenses left to the patient’s responsibility on their primary insurance Explanation of Benefits (EOB), such as co-pays, deductibles, and coinsurance for eligible medical treatment.

Q. What documents are needed in order for the Student Accident Insurance to process a claim?

A. The provider must submit the following documents to the claims company (First Agency):

1) **Itemized Medical Bill** – The provider will either bill the claims administrator with a **HCFA 1500** or **UB04**, and it will contain the following information:
   - Provider’s Name and address
   - Tax ID Number
   - Date(s) of Service
   - Diagnostic Code(s) and Procedure Code(s)
   - The Fee for Each Procedure

2) **Primary Explanation of Benefits** (EOB) – This is a statement from your primary insurance company that outlines what charges will be covered or denied, and what will be left as patient responsibility (co-pay, coinsurance, deductible, etc.).

Q. How long is a student covered under the policy?

A. The policy has a two year benefit period from the date of a covered injury.

Q. What if a student already paid bills that they received from a covered activity injury after primary insurance paid? Is there a way to seek reimbursement?

A. Reimbursements can be processed under this policy, however, it can require additional documentation for the student to track down the necessary documentation once a medical provider has been paid in full. First Agency. will need the receipt or other proof of payment in addition to the Itemized Claim (HCFA 1500 or UB04) and primary insurance EOB.

For Additional Questions Please Contact:

First Agency
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Kalamazoo, MI 49009
Phone: (269) 381-6630
Fax: (269) 381-3055
Email: Charlie_Eisenbies@ajg.com

Gallagher | Student Health & Special Risk