Claim Serial Number (for office use only)

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

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

Student's Full Name _____ Exact Date of Accident _____

Student's Social Security Number _____ Student's Date of Birth _____

Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extention Act of 2007.

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 _____

Social Security Number _____

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 _____

Social Security Number _____

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.

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any kind, and all such information is to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, or its authorized Administrators or their legal representatives.

Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HI, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request. I also authorize any Berkley Group Company or its authorized Administrators to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

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.

Important Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

_____
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

Notice to CALIFORNIA RESIDENTS - Please refer to the attached Notice of Personal Information Collected pursuant to California Consumer Privacy Act (CCPA)

PLEASE COMPLETE NEXT PAGE

SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends _____ in Abbotsford School District 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: _____

PLEASE COMPLETE PREVIOUS PAGE

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 ***ACCIDENTS*** that occur in school-sponsored and supervised activities including participants in interscholastic sports are covered.

DEFINITION OF ACCIDENT:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

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. Failure by a Covered Person to follow the terms and conditions of His primary coverage will result in a benefit reduction of Eligible Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

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, 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 false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Accidents must be reported to the school within 20 days. Medical bills must be submitted to First Agency within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency 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.)

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:** **First Agency**
5071 West H Avenue
Kalamazoo, MI 49009-8501

Abbotsford School District / WI

W. R. Berkley Corporation
Notice of Personal Information Collected
(Pursuant to the California Consumer Privacy Act (CCPA))

This notice applies only to information received and collected by W. R. Berkley Corporation ("Berkley") from residents of the state of California.

In this notice, when we refer to "we", "us" or "our", it means one or more operating units of W. R. Berkley Corporation ("Berkley operating units").

When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.

Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.
Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?

For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019