AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand the _____ District, its employees and its Board (1) assume no liability of any nature in relation to the transportation or treatment of said minor, and (2) is not responsible for the medical bills in the event of an injury to my child.

FAMILY DOCTOR	ADDRESS	DATIME PHONE
HEALTH PLAN/INSURANCE (I.E. BLUECROSS)		GROUP/POLICY NO.
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:		
OTHER MEDICATIONS BEING USED:		
MY CHILD HAS THE FOLLOWING HEALTH PROBLEMS:		
SIGNATURE OF PARENT OR GUARDIAN:		DATE:

Myers-Stevens & Toohey & Co.
26101 Marguerite Parkway
Mission Viejo, CA 92692-3203
Ph: 800-827-4695 Fax: 949-348-2630

Instructions:
1) Complete this form
2) Attach all bills
3) Mail to: Myers-Stevens & Toohey

STUDENT ACCIDENT COVERAGE – ACCIDENT CLAIM FORM

PART A ~ SCHOOL STATEMENT

1 Injured Student Name: First MI Last	Student Soc. Security #	Student DOB:
2 Name of AML/JIA Member School District:	Student Age & Grade:	☐ Male ☐ Female
3 Injury Occurred: ☐ practice ☐ game ☐ P.E. ☐ classroom ☐ travel ☐ field trip ☐ at home ☐ other	Date of Injury: month/day/year	Time of Injury:
Details on how the injury occurred: (please be specific)	What part of the body was injured?	School telephone number: School FAX number:
4 Name of Supervisor/Teacher (school):	Date school was notified of incident:	Did Supervisor/teacher witness incident?
5 Name of Official/Superintendent/Principal	Signature of official: **X**	Date Signed:

PART B ~ PARENT OR GUARDIAN STATEMENT

6 Relationship to Injured Student: ☐ Father ☐ Mother ☐ Guardian ☐ Other	Is this dependent covered by another health and/or accident insurance plan? ☐ Yes ☐ No	
7 Name of **Father or Male** Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
8 Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
9 Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
10 Address of other coverage:	City/State:	Zip Code:
11 Name of **Mother or Female** Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
12 Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
13 Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
14 Address of other coverage:	City/State:	Zip Code:

15 Name, address and telephone number of family physician:

16 Has the student suffered from same or similar condition before?
☐ Yes ☐ No If Yes, when?

I understand that any parent who knowingly, and with intent to defraud any insurance company or other person, files a statement of a claim containing any materially false information, or conceals, for the purpose of misleading, information concerning facts material, thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.	Signature of Parent or Guardian: **X**
I hereby authorize any school authority, employer, or insurance company, or person who has attended to or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc. or the AMLJIA, when requested to do so, any information regarding any injury or illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or itemized bills, and to pay benefits based upon this information. Photocopy of this authorization shall be considered as valid and effective as the original.	Relationship to injured student:
Authorization to pay benefits to provider: I authorize payment of Medical payments to Physician or Supplier for services on the attached.	Signature of Parent or Guardian: **X**

STUDENT ACCIDENT COVERAGE – SUMMARY DESCRIPTION OF BENEFITS

2020-2021 SCHOOL YEAR

We will pay usual, customary and reasonable medical and dental charges, as defined by the policy, subject to exclusions, requirements and limitations for necessary supplies and services as follows.

ACCIDENT MEDICAL BENEFITS

Hospital Services	
1. Daily Room & Board - Semi-Private	80% Usual and Customary
2. Intensive Care Room & Board	80% Usual and Customary
3. Miscellaneous Services - when hospital confined or when surgery is performed.	80% Usual and Customary
4. Emergency Room (outpatient)	80% Usual and Customary
Physician Services	
1. Surgery, including pre-and postoperative care	80% Usual and Customary
2. Anesthetic (including administration and Assistant Surgeon	80% Usual and Customary
3. Physician Visits other than physiotherapy and similar treatment, when no surgery benefits paid.	80% Usual and Customary
4. Consultants (when required by attending physician for confirming or determining a diagnosis but not for treatment) and Second Opinions.	80% Usual and Customary
5. Diagnostic Imaging/MRI/Cat Scan	80% Usual and Customary
Laboratory & X-Rays	
1. Includes reading and interpretation	80% Usual and Customary
2. Dental x Rays	80% Usual and Customary
Additional Services	
1. Physiotherapy or similar treatment; In Hospital - Out of Hospital	80% Usual and Customary
2. Registered or Licensed Nurse	80% Usual and Customary
3. Ambulance to initial treatment facility including Air Transport	80% Usual and Customary $1,500 maximum benefit per injury
4. Orthopedic Appliances (includes rental of crutches or wheelchair); In Hospital - Out of Hospital	80% Usual and Customary
5. Prescribed Drugs or Medicines	80% Usual and Customary
6. Eyeglasses, when damaged in conjunction with a covered injury requiring medical treatment.	80% Usual and Customary
7. Psychiatric or Psychological counseling required due to covered paralysis or dismemberment	$5,000
Dental Services	
1. Treatment, repair or replacement of injured natural teeth. Includes initial braces when required for treatment of a Covered Accident, as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma.	80% Usual and Customary

ACCIDENT MEDICAL BENEFITS *Cont'd*

Plan Limits	
1. Base Plan	$25,000 per injury
2. Benefits paid on Full Excess Basis	Yes
Deductible	$50 per injury

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, OR PARALYSIS BENEFIT

Benefits	
1. Loss of Life	$10,000
2. Loss of Both Hands	$10,000
3. Loss of Both Feet	$10,000
4. Loss of Entire Sight of Both Eyes	$10,000
5. Quadriplegia (total paralysis of both lower limbs)	$10,000
6. Paraplegia (total paralysis of both lower limbs)	$10,000
7. Hemiplegia (total paralysis of upper and lower limbs on one side of body)	$10,000
8. Loss of One Hand	$5,000
9. Loss of One Foot	$5,000
10. Loss of Entire Sight of One Eye	$5,000

DESCRIPTION OF COVERED PERILS

1. The hazards for which coverage is provided are such injuries occurring to the covered person:
   a. At school during the school day while continuously on school premises (including academic summer classroom sessions) and
   b. While attending or participating in activities sponsored and under the direct and immediate supervision of the school
   c. While traveling in school provided and operated vehicles.
   d. While traveling directly and without interruption between school and the site of an activity sponsored and under the direct and

DESCRIPTION OF EXCLUDED PERILS (including but not limited to)

1. Intentionally self inflicted injury.
2. Injury or death caused while riding in or on, entering into or alighting from a two or three-wheeled motor vehicle.

CLAIM ELIGIBILITY

1. Injuries must be solely and directly the result of participation in a covered activity.
2. Injuries must be reported immediately to a school official and initial treatment must be sought within 120 days of the injury.
3. Coverage for expenses must be first incurred within 120 days of the date of the injury, and in no event, after 365 days after the date of the first treatment for the injury. However, should the injury sustained require the removal of surgical pins, or continued treatment for serious burns, or treatment of non-union or mal-union of a covered fracture, the benefit period will be extended to 104 weeks for that condition.

This document is not meant to expand or amend AMLJIA coverage documents, nor should it be used in the determination of liability for any particular claim. For specific details, please refer to the AMLJIA Participant Coverage Memorandum and other official coverage forms. All matters of interpretation are to be construed in favor of these documents.

Craig City School District

P.O. Box 800, Craig, Alaska 99921
www.craigschools.com
Phone (907) 826.3274
FAX (907) 826.3322

Chris Reitan, Superintendent
Jackie Hanson, Elem./MS Principal
Kim Brand, HS Principal
Mollie Harings, PACE Principal

2020-2021 School Year
RE: Student Injuries and Insurance

Dear Parent:
At no cost to you, we have obtained Student Accident Coverage through the Alaska Municipal League Joint Insurance Association (AMLJIA) for some accidents that occur during school activities, to help with the cost of medical treatment not covered by other insurance you may have. Your child's school is NOT responsible for any medical bills should your child become injured at school – this means that you are responsible for any medical charges not covered by insurance for your child. This "school-time" coverage is designed to cover some, but not all, of the possible charges. A Summary Description of Benefits is enclosed for your reference.
This coverage will help you pay up to $25,000 in the event of a covered accident and takes effect only after any other medical insurance that is available has paid. The coverage has a $50 deductible and pays 80% of usual, customary and reasonable charges. If this coverage is used, you will be responsible for a $50 deductible per accident and for the remaining co-payment. In some cases there may be no deductible if other primary medical insurance is in effect. If your child does have other health coverage, student insurance may also be used to help pay those eligible charges not covered by other insurance (i.e., deductibles and co-payments).

Please sign and return the Authorization for Emergency Medical Treatment form to the school office immediately. This is important to protect the health of your child in the event of an injury. In the event of a school-related injury, please report the injury to the school office within 72 hours. Also, please review the description of benefits carefully. If you have any questions, I encourage you to contact your school district office.

NOTE: Many families have seen their health insurance benefits reduced if not eliminated altogether. For this reason, we've made arrangements to give students access to a number of optional accident/sickness insurance plans for voluntary purchase. These plans may be used to reduce, if not eliminate, any costs to you associated with most school related injuries. They can also be used to extend accident and sickness coverage for your child 24/7. Please carefully review the accompanying brochure/enrollment form and consider your own family's needs. If you have questions or need assistance, please contact the plan administrator, Myers-Stevens & Toohey & Co., at 800-827-4695 or visit www.myers-stevens.com.
Thank you for your prompt attention to this matter.