STUDENT ATHLETIC/ACCIDENT INSURANCE

1) The District has a Student Athletic Accident Insurance policy that provides benefits for injuries sustained during Athletic participation. The policy also includes Band, Cheerleading, Majorettes, Physical Education classes and Field Trips. This plan of insurance is secondary/supplemental to any health insurance you may have. As such, all expenses must be submitted to your own insurance first.

   When you file a claim a Claim Form should be partially completed by the School, and then given to you for further completion. You must inform the providers of treatment that there is secondary insurance coverage through the District and give them the claim office's name, mailing address, telephone number and policy number all of which can be found at the top of the Claim Form. The completed Claim Form should then be sent to the claims office.

   Note: The Athletic Accident Insurance policy benefits are limited and therefore may not provide 100% coverage.

2) Parents may also purchase additional insurance at their own cost described in the attached brochure. This Voluntary insurance can provide benefits for injuries that your child may sustain during the school day, or even out of school, depending upon the plan that you purchase. Enrollment in the Voluntary insurance is done directly with the insurance carrier either online or by completing and mailing the enrollment form included in the attached brochure.

Included in this brochure are:

A) The Student Athletic Accident Claim Form that is to be used, if needed, to file a claim for an injury.

B) The optional Voluntary insurance information and application that parents have the option of purchasing at their own expense.

A

Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH ITEMIZED BILLS & EOBS FROM PRIMARY CARRIER
3. SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS
4. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Email: helpme@webtpa.com

IMPORTANT NOTICE:
Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills, with diagnosis, and this completed form. **SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS ON FILING A CLAIM.** Note: **The accident policy benefits are limited and may not provide 100% coverage.**

< IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED >

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name Wachusett Regional School District, MA Policy Number 21-3638-16

School/Team/League Name _____ Phone No. ( )_____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other _____

Date of Accident _____ Accident Time _____ Date of First Treatment _____

Where and how did accident occur? (Please be specific) _____

_____

_____

_____

Part of body Injured _____ At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? _____ Was he/she a witness? ☐Yes ☐No

Authorized Signature _____ Title _____ Date _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Claimant's Name _____ Social Security # _____

Date of Birth _____ Age _____ Grade Level _____ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Day Care ☐Participant ☐CE Student (# of credits_____)

Address of Claimant or Parents/Guardian _____

_____

Phone No. ( )_____ Email Address _____

Name and Address of Family Physician _____

_____

Phone No. ( ) _____ Has treatment been completed? ☐Yes ☐No

Claimant or Father/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

Claimant or Mother/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company **Address** **Policy #**

_____

_____

_____

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No (See IMPORTANT NOTICE at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party _____

_____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Claimant, Parent or Guardian _____ Date: _____

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Claimant, Parent or Guardian _____ Date: _____

PLEASE READ

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

♦ Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦ If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits notice from your primary carrier, send it to us along with the corresponding itemized bills and with the fully completed claim form. You must submit itemized bills; balance due statements will not be processed. Itemized bills include:

1) HCFA-1500 (standard form used by Providers)
2) UB-04 or UB-92 (standard form used by Hospitals)

♦ If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

♦ Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

♦ If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦ Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

B

2016 – 2017 STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity. No coverage is provided while participating in Interscholastic Sports.

Annual Premium: **Superior - $35.00** **Elite - $18.00** **Preferred - $11.00** **Basic - $10.00**

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. No coverage is provided while participating in Interscholastic Sports.

Annual Premium: **Superior - $160.00** **Elite - $88.00** **Preferred - $55.00** **Basic – 50.00**

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium:$8.00**

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

PRIMARY COVERAGE PROVISION Benefits are payable for covered medical expenses from the first dollar of expense incurred. Benefits are paid in addition to and without regard to payments from other insurance.

MEDICAL BENEFITS When a covered Injury to a student results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of Injury, the Company will pay the benefit as shown in the Schedule of Benefits, subject to the full Primary Coverage Provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT When a covered Injury results in any of the Losses to the Insured which are stated in the Schedule of Benefits for Accidental Death, Dismemberment, or Loss of Sight then the Company will pay the benefit stated in the schedule for that Loss. The Loss must be sustained within 365 days after the date of the Accident.
The maximum benefit payable under this provision is stated in the Schedule of Benefits under Maximums and Benefit Period: 1) Life 2) Both Hands or Both Feet or Sight of Both Eyes; 3) Loss of One Hand and One Foot; 4) Loss of One Hand and Entire Sight of One Eye; 5) Loss of One Foot and Entire Sight of One Eye; 6) Loss of One Hand or Foot; 7) Loss of Sight in One Eye; 8) Loss of Thumb and Index Finger of the Same Hand. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot or the Sight of one eye. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount the Company will pay is the maximum benefit. Benefits paid under this provision will be paid in addition to any other benefits provided by the Policy. Benefits under this provision are subject to all other provisions of the Policy, including all Coverage and Limitations, Maximums and Exclusions.

DEFINITIONS Injury means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event causing bodily Injury, independent of disease or bodily infirmity. The Accident must occur while the Insured is covered under the Policy. **Reasonable Expense** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

EXCLUSIONS No Benefits are payable for Hospital and Professional Services for the following: 1) Injuries which are not caused by an Accident; 2) Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis; 3) Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile; 4) Aggravation, during a Regularly Scheduled Activity, of an Injury the Insured suffered before participating in that Regularly Scheduled Activity, unless the Company receives a written medical release from the Insured's Physician; 5) Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid; 6) Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; 7) Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School; 8) Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; 9) no indemnity will be paid for Loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his physician for the insured; 10) Medical expenses for which the Insured is entitled to benefits under any (a) Workers' Compensation act; or (b) mandatory no-fault automobile insurance contract; or similar legislation; 11) Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. **IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form COL-11(CT), underwritten by Gerber Life Insurance Company (the Company). If there is any conflict between this brochure and the Policy, the Policy will prevail. Please see the Master Policy for individual state details.**

HOW TO FILE A CLAIM

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss.

In the event of an Accident, students should: 1) Secure treatment at the nearest medical facility of their choice; 2) Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills and the fully completed and **signed** accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415; and 3) **Call 1-866-975-9468** with any Claims questions.

UNDERWRITTEN BY:
Gerber Life Insurance Company
White Plains, NY 10605

MARKETING AGENT:
Lefebvre Insurance, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

To apply for coverage, please enroll on-line with a credit card at www.k12specialmarkets.com ***or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.***

Please Return To: K12Special Markets Plan Administrators
1265 Main Street, Suite 202
Stevens Point, WI 54481

2016 – 2017 ENROLLMENT APPLICATION (please print or type)

Student's Last Name _____ Student's First Name _____ Student's Middle Initial _____ Grade _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Birthdate _____

School System _____ Name of School _____

Check your selection:

Superior	❑ School-Time $35.00	❑ 24-Hour Accident $160.00	❑ 24-Hour Dental $8.00
Elite	❑ School-Time $18.00	❑ 24-Hour Accident $ 88.00	❑ 24-Hour Dental $8.00
Preferred	❑ School-Time $11.00	❑ 24-Hour Accident $ 55.00	❑ 24-Hour Dental $8.00
Basic	❑ School-Time $10.00	❑ 24-Hour Accident $ 50.00	❑ 24-Hour Dental $8.00

Please make check payable to Gerber Life Insurance Company

Total Enclosed: _____

Signature of Parent or Guardian _____ Date _____

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SCHEDULE OF BENEFITS

Coverage for Injuries due to Accidents only

Maximum Benefit:	**Superior**	**Elite**	**Preferred**	**Basic**
School-Time Option	$100,000	$75,000	$50,000	$25,000
24-Hour Option	$100,000	$75,000	$50,000	$25,000
Injuries Involving Motor Vehicles	$ 10,000	$10,000	$10,000	$10,000
Death Benefit/Double Dismemberment	$ 10,000	$10,000	$10,000	$ 2,500
Single Dismemberment	$ 5,000	$ 5,000	$ 5,000	$ 2,500
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury			
Benefit Period for Medical and AD&D/Loss of Sight Benefits	2 Years	2 Years	2 Years	2 Years
Excess Coverage Applicability	Primary	Primary	Primary	Primary
Hospital/Facility Services - Inpatient				
Hospital Room and Board (Semi-Private Room Rate)	100% RE*	100% RE*	80% RE* / $200 Max. per day	$200 Maximum per day
Hospital Intensive Care	100% RE*	100% RE*	80% RE* / $200 Max. per day	$400 Maximum per day
Inpatient Hospital Miscellaneous	$10,000 Maximum	$7,500 Maximum	$5,000 Maximum	$1,000 Maximum
Hospital/Facility Services - Outpatient				
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	$750 Maximum	80% RE* / $500 Max.	$250 Maximum	$150 Maximum
Free-standing Ambulatory Surgical Facility	$2,000 Maximum	80% RE* / $1,000 Max.	$500 Maximum	$250 Maximum
Hospital Emergency Room Physician	$75 Maximum	$50 Maximum	$50 Maximum	$50 Maximum
Hospital Emergency Room	$500 Maximum	80% RE* / $350 Max.	80% RE* / $150 Maximum	100 Maximum
Physician's Services				
Surgical	80% RE* / $3,000 Max.	80% RE* / $2,000 Max.	80% RE* / $1,000 Max.	50% RE* / $1,000 Max.
Assistant Surgeon	25% Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Non-surgical Treatment (Except as below)	$60 per day	$500 Maximum	$25 per day	$20 per day
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	$75 /Visit / 5 Visits Max.	$40/Visit / 5 Visits Max.	$25/Visit / 5 Visits Max.	$20/Visit / 5 Visits Max.
Other Services				
Registered Nurses' Services	100% RE*	100% RE*	80% RE*	100% RE*
Prescriptions - outpatient	100% RE*	100% RE*	80% RE*	80% RE*
X-rays, includes interpretation - outpatient	$300 Maximum	$250 Maximum	$200 Maximum	$100 Maximum
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	$1,000 Maximum	$750 Maximum	$300 Maximum	$200 Maximum
Ambulance	100% of the amount equal to the lesser of the billed charge or the maximum allowable rate established by the CT Department of Public Health.			
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	$500 Maximum	$300 Maximum	$150 Maximum	$75 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	$700 Maximum	$500 Maximum	$150 Maximum	$200 Maximum
Dental Treatment to sound, natural teeth due to covered injury.	$2,000 Maximum	$1,500 Maximum	$1,000 Maximum	$500 Maximum

***RE means Reasonable Expense**

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