2025-2026

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# 2025-2026 Workers' Compensation Packet (Revised 2025.09.26)

**If you experience a work-related injury, please complete the following steps:**

1. **Report the incident to your building principal/supervisor immediately!**
2. **Emergency Care:**
   a. If you require ***immediate*** attention please go to the nearest emergency room then complete an injury report after you have received medical attention.
3. **Non-Emergency Care:**
   a. If you do not require immediate attention or if you have already received care at the emergency room, meet with your building principal/supervisor to complete the worker's comp packet
   b. The workers' comp packet can be obtained:
      i. From your building secretary or nurse
      ii. Online on the District website (HR page under Employee Information)
4. Except in the case of urgent medical need, **forward the workers comp packet to Human Resources**
   a. You may drop off the paperwork in person or
   b. Scan and email it to HR
      i. Make sure to send any originals to HR via interoffice mail
5. **UPMC GoHealth Urgent Care**
   a. If you choose to seek care from a UPMC GoHealth Urgent Care center, please let HR know so that we can provide you with an authorization form to take with you
   b. Schedule an appointment at the UPMC GoHealth Urgent Care center using this QR code or at www.gohealthuc.com

Note: A listing of designated physicians and medical providers is included in the workers' comp packet. Please refer to this list ***prior*** to scheduling an appointment. Inform the designated medical provider that you were injured at work. They will invoice directly to the workers' compensation insurance company. **UPMC Go Health Urgent Care centers require an authorization form from HR.**

**Absence/Lost-Time Injury**

- Obtain a written statement from the physician indicating the **reason for an absence A*ND* the expected return to work date.**
- In the event of a **lost-time injury**, you must inform the Payroll Department of your progress/status on a ***weekly* basis.**
  - Physician's statement must be presented to Human Resources
  - Keep your supervisor informed of your status
  - Note: Effective Sept 1, 2004, voluntary payroll deductions, such as the Credit Union, may be reduced or eliminated in order for the District to receive any monies owed by the employee due to a workers' compensation claim.
  - Reimbursement will be made in a lump sum on a case-by-case basis. We will not spread reimbursements over multiple pays if possible. - Canon-McMillan School District Business Office

**Encova provides Canon-McMillan School District with Workers' Compensation Insurance.**

BrickStreet Mutual Insurance Company

400 Quarrier Street

Charleston, WV 25301

Phone: 1-844-362-6821

# Report of Injury

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| | | |
|---|---|---|
| Employer's Name: **CANON-MCMILLAN SCHOOL DISTRICT** | | **INCIDENT INFORMATION** |
| Address, City, State, ZIP: 200 BIG MAC BLVD<br>CANONSBURG, PA 15317<br>Employer's Phone: 724-746-2940 | | Date of Incident |
| Injured Worker's Last Name, First Name, Middle Initial | | Date incident reported |
| Home Street Address: | | Work start time |
| City, State, ZIP | | Time of incident |
| Phone Number | Date of Birth | Date of Hire |
| Occupation | | Length of time in current position |
| ❑ Full-time<br>❑ Part-time | If Part-Time, Days Worked (Please circle)<br>Mon Tues Wed Thur Fri Sat Sun | Losing Time? (Please circle)<br>Yes No<br>Last day worked: |
| Supervisor's Name | | Supervisor's Phone Number |

Did incident occur on employer's premises? (Please circle answer) Yes No

Where:

Performing regular job at the time of incident? (Please circle answer) Yes No

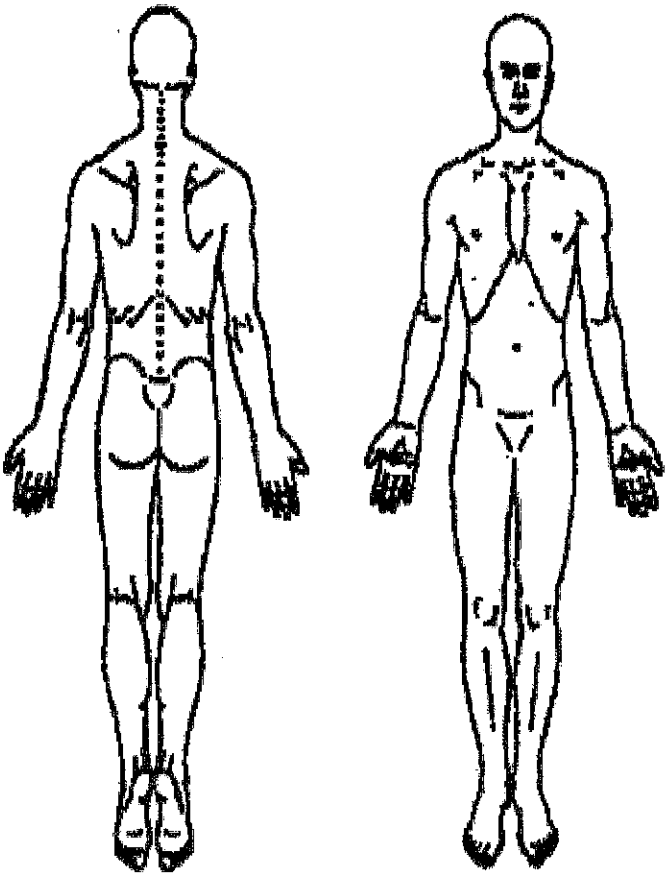
Description of incident (who, what, when, where, how, and why):

Employee Name:

List of body parts injured:

**Body Part(s) Injured (Check ALL that apply AND circle the areas on the body diagram provided):**

- ☐ Arm
- ☐ Abdomen
- ☐ Ankles
- ☐ Back
- ☐ Chest Ribs
- ☐ Ears
- ☐ Elbow
- ☐ Eyes
- ☐ Face
- ☐ Feet
- ☐ Fingers
- ☐ Full Body
- ☐ Groin
- ☐ Hand
- ☐ Head
- ☐ Hip
- ☐ Internal
- ☐ Knees
- ☐ Legs
- ☐ Mouth/ Teeth
- ☐ Neck/ Throat
- ☐ Nose
- ☐ Pelvis
- ☐ Shoulder
- ☐ Skin
- ☐ Toes
- ☐ Wrist
- ☐ Other _____



**Type of Injury (Check all that apply)**

- ☐ Abrasion
- ☐ Amputation
- ☐ Burn
- ☐ Chemical reaction
- ☐ Crush
- ☐ Cut/ Laceration
- ☐ Death
- ☐ Dislocation
- ☐ Fracture
- ☐ Puncture
- ☐ Shock/electrocution
- ☐ Sprain/ Strain

Prior injuries and with what employer:

Treatment sought and with whom:

Name and phone number of witnesses:

Remarks:

| Employee's Signature: | Date: | Time: |
|---|---|---|
| Supervisor's Signature: | Date: | Time: |

**Fraud Statement:** Any person who knowingly and with intent to defraud any insurance company, or files an application for insurance or statement of claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties.

# Workers Compensation Payroll Options

Listed below are payroll options that are available to District employees eligible for Workers' Compensation payments. Please indicate how you would like your Workers' Compensation payments handled upon your return to work.

Notes:

- When choosing **Option 1**, there may be a delay in the start of Workers' Compensation
- **Copies** of all Workers' Compensation payments must be given to the District payroll department

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An employee *cannot* receive more in compensation and earnings combined. Therefore, it is necessary to adjust your pay for either option.

_____ **OPTION 1**

I wish to receive only Workers' Compensation payments and receive ***no pay*** from the Canon-McMillan School District during the time that I am on Workers' Compensation. No sick days will be charged to my sick time. However, I understand that my pay will be adjusted to compensate for any overpayment I may have received from the District.

_____ **OPTION 2**

I wish to ***continue with my regular pay*** from the Canon-McMillan School District. I understand that I will be charged a sick day for each day of Workers' Compensation leave.

My pay will be recalculated and the value of the total Workers' Compensation payments will be deducted from my pay. The appropriate number of sick days will be returned to my sick time. This will be done on an ongoing basis.

Please bring copies of your Workers' Compensation check stubs (either weekly or biweekly) to Central Office in order for your pay to be adjusted each time you are paid by the District.

Name (please print): _____

Signature: _____ Date: _____

Building/School: _____

Days of Absence: _____

**Please return all completed forms to Central Office**

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# MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

| HIV/AIDS | Behavioral health | Drug and alcohol | Genetic history |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ _____

Signature of individual | Date

_____ _____

Social Security number | Date of birth

_____

Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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## EMPLOYEE'S RIGHTS & DUTIES UNDER SECTION 306 (F.1) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

During the 90-day period, you may change from one designated physician or health care provider on the list to another physician or health care provider on the list, and the treatment will be paid for by the employer.

If the designated physician or health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider however, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

If the employer-designated physician or health care provider recommends invasive surgery, you are permitted to obtain a second opinion from a non-designated physician or health care provider. Your employer will pay for the cost for this opinion. If this opinion differs from the opinion of the designated physician or health care provider and provides a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment however must be provided by a designated physician or health care provider for 90 days from the date of the visit to the non-designated physician.

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or 1-717-783-5421.

**I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND THE ABOVE RIGHTS AND DUTIES.**

| | | |
|---|---|---|
| Employee name | Employee signature | Date |
| Supervisor name | Supervisor signature | Date |

*IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.*

| | | |
|---|---|---|
| Supervisor name | Supervisor signature | Date |

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## NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of six or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

### MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least six providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

### MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

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Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

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# Canon McMillan School District - Washington County

**Your Workers' Compensation Insurance Carrier is:**

**Encova Insurance**

**PO Box 3151 Charleston, WV 25332**

**Phone: 1-866-452-7425**

## NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

| Name | Address | Phone | Area of Specialty |
|---|---|---|---|
| Washington Health System<br>(Multiple Locations) | 95 Leonard Avenue, Building 1, Suite 401<br>Washington, PA 15301 | 724-223-3528 | Occupational Medicine |
| UPMC GoHealth Urgent Care<br>(Multiple Locations) | 3840 Washington Road, Suite 300<br>McMurray, PA 15317 | 724-941-3273 | Urgent Care/Occupational Medicine |
| Medical Rehabilitation Inc<br>(Multiple Locations) | 110 Fort Couch Road<br>Pittsburgh, PA 15241 | 412-831-2300 | Physiatry |
| Abraham Kabazie, MD<br>Institute for Pain Medicine at the Western Pennsylvania Hospital | 5124 Liberty Avenue, 1st floor<br>Pittsburgh, PA 15224 | 412-315-3800 | Pain Management |
| Thomas A Mutschler, MD<br>Allegheny Orthopaedic Institute | 100 Medical Blvd<br>Canonsburg, PA 15317 | 724-873-5955 | Orthopedics |
| Penn Highlands Orthopedics and Sports Medicine<br>(Multiple Locations) | 625 Lincoln Avenue<br>Professional Plaza, Suite 107<br>Charleroi, PA 15022 | 724-379-5802 | Orthopedics |
| UPMC Orthopedic Care | 95 Leonard Avenue, Building 1, Suite 202<br>Washington, PA 15301 | 724-206-0610 | Orthopedics |
| Jefferson Hills Surgical Specialists<br>(Multiple Locations) | 1200 Brooks Lane, Suite 170<br>Jefferson Hills, PA 15025 | 412-469-7110 | General Surgery |
| Associates in Neurology of Pittsburgh<br>(Multiple Locations) | 575 Coal Valley Road, Suite 104<br>South Hills Medical Building<br>Clairton, PA 15025 | 412-466-3111 | Neurology |
| AHN Neuroscience<br>(Multiple Locations) | 4815 Liberty Avenue, Suite 439<br>Pittsburgh, PA 15224 | 412-578-3925 | Neurosurgery |
| Ernest R Salvitti, MD<br>Southwestern PA Eye Center<br>(Multiple Locations) | 750 East Beau Street<br>Washington, PA 15301 | 724-228-2982 | Ophthalmology |
| Edward J Chang, MD<br>Everett & Hurite Ophthalmic Associates<br>(Multiple Locations) | 3001 Waterdam Plaza, Suite 120<br>McMurray, PA 15317 | 724-942-0737 | Ophthalmology |

**CONVENIENT NETWORK LOCATIONS LISTED BELOW**

| | | | |
|---|---|---|---|
| PCS PT Network | Call Toll Free for Closest Location | 1-888-594-4001 | Physical Therapy |

| | | | |
|---|---|---|---|
| PCS Diagnostic Network | Call Toll Free for Closest Location | 1-888-594-4001 | Diagnostic Testing |
| Mitchell ScriptAdvisor | Call Toll Free for Closest Location | 1-866-846-9279 | Pharmacy |

**Panel Date: 8/15/2025**

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# PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name | Claimant number | Date of injury

Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

| | | | | | |
|---|---|---|---|---|---|
| **Standing** | ☐ Constantly | ☐ Frequently | ☐ Occasionally | ☐ Rarely | ☐ Never |
| **Sitting** | ☐ Constantly | ☐ Frequently | ☐ Occasionally | ☐ Rarely | ☐ Never |
| **Walking** | ☐ Constantly | ☐ Frequently | ☐ Occasionally | ☐ Rarely | ☐ Never |
| **Climbing** | ☐ Constantly | ☐ Frequently | ☐ Occasionally | ☐ Rarely | ☐ Never |
| **Kneeling** | ☐ Constantly | ☐ Frequently | ☐ Occasionally | ☐ Rarely | ☐ Never |
| | >67% of workday | 34% - 66% of workday | 6% - 33% of workday | <5% of workday | 0% of workday |

Please indicate the extent to which the employee can perform the following:
(C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

| **Lifting/carrying** | C | F | O | R | N |
|---|---|---|---|---|---|
| 5 lbs. or less | | | | | |
| 5–10 lbs. | | | | | |
| 11–20 lbs. | | | | | |
| 21–40 lbs. | | | | | |
| 41–60 lbs. | | | | | |
| 61–100 lbs. | | | | | |
| 100+ lbs. | | | | | |
| **Activity** | | | | | |
| Bend | | | | | |
| Squat | | | | | |
| Twist/turn | | | | | |
| Crawl | | | | | |
| Reach above shoulder | | | | | |
| Type/keyboard | | | | | |
| Joystick/ hand controls | | | | | |
| Vibration | | | | | |
| Comments | | | | | |

| **Pushing/pulling** | C | F | O | R | N |
|---|---|---|---|---|---|
| 5 lbs. or less | | | | | |
| 5–10 lbs. | | | | | |
| 11–20 lbs. | | | | | |
| 21–40 lbs. | | | | | |
| 41–60 lbs. | | | | | |
| 61–100 lbs. | | | | | |
| 100+ lbs. | | | | | |
| **Driving** | | | | | |
| Automatic drive | | | | | |
| Standard drive | | | | | |

| **Upper extremities** | Yes | | No | |
|---|---|---|---|---|
| Simple grasping | ☐ Right | ☐ Left | ☐ Right | ☐ Left |
| Pushing/pulling | ☐ Right | ☐ Left | ☐ Right | ☐ Left |

| **Operate foot controls** | Yes | | No | |
|---|---|---|---|---|
| | ☐ Right | ☐ Left | ☐ Right | ☐ Left |

Simultaneous ☐ Yes ☐ No

Physician name | Physician telephone

Date released with above restrictions | Date released for full-duty work

Projected date for MMI | Date and time of next appointment

Physician signature | Date

# Mitchell ScriptAdvisor

## Workers' Compensation *FIRST FILL* – Temporary Prescription Card

**Mitchell** ScriptAdvisor has been selected by **Encova Insurance** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

### Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

### Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

**Mitchell ScriptAdvisor**

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: **Process through Script Care and Enter RxBIN, RxPCN and GROUP.**

Member Name:

Member ID #:

**Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)**

| | |
|---|---|
| Rx BIN: | 019082 |
| PCN: | MPS |
| Group: | MPS001536TC |

Walmart · RITE AID · Longs Drugs · CVS pharmacy · TARGET · Walgreens · SAFEWAY

## Questions?
## Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International
866.221.6588
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