Effective July 1, 2016 through June 30, 2017

SCOTT COUNTY BOARD OF EDUCATION

TO: Parent/Guardian:

The Scott County Board of Education will provide accident insurance for the 2016-2017 school year for all students. Please note that the insurance is "secondary" to any other insurance coverage the family may have and will pay only on eligible medical expenses not payable by other sources of coverage.

Benefits

The policy pays 100% of reasonable, customary and Medically Necessary covered expenses which result from an accident which occurs while participating in a school-sponsored, school-supervised activity. The policy includes a $1000 Physical Therapy benefit. The Basic policy provides benefits for both students and athletes up to the policy maximum of $25,000 for two years from the date of injury. For students and middle school athletes and below, the Catastrophic coverage provides benefits from $25,000 up to $5,000,000, and for high school athletes the Catastrophic coverage is provided by the Kentucky High School Athletic Association. This is a brief summary of benefits and all claims are paid per the policy provisions.

How to File a Claim

To process your claim please submit the following three pieces of information:

1. Completed and Signed Claim Form
2. Itemized Bills
3. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed or faxed to:

A-G Administrators, Inc.
Claims Department P.O. Box 979
Valley Forge, PA 19482
(610) 933-4122 Fax
(610) 933-0800 Phone
(800) 634-8628 (Toll Free)

1. The Claim Form enables A-G Administrators, Inc. to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure the "other insurance" portion of the claim form is completed in full. The claim form must be signed by a school official such as a principal, coach or athletic trainer.

2. Itemized Bills: Please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account statements or "Balance due" statement are helpful, but do not contain all the information needed to process the charges.

3. Explanation of Benefits: If you have other medical insurance, all medical bills must be first submitted to that carrier for their determination of eligibility. If the charges are not paid in full by the other medical insurance carrier we will need to see a copy of the "Explanation of Benefits" from that carrier prior to issuing benefits from this office. If you have primary medical insurance the need for an "Explanation of Benefits" will not be applicable to your claim.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR CLAIM, PLEASE CALL:

A-G Administrators, Inc.
1-800-634-8628

-or-

Debbie Frick or David Livingston
Roeding Insurance
1-859-296-4580

Tips for Efficient Claim Processing

1. The Claim Form must be completed in its entirety and signed by both parents and a school official.

2. The date of the accident and a detailed description are required to verify that the incident was school-related.

3. The claim form should be submitted to A-G Administrators, Inc. within 60 days of the accident. **THE BASIC COVERAGE HAS A BENEFIT PERIOD OF TWO YEARS FROM THE DATE OF THE ACCIDENT. TREATMENT MUST OCCUR WITHIN 60 DAYS OF THE ACCIDENT.**

4. In addition to the claim form, the company will also require the following in order to make payment:

   - Itemized physician, hospital, or other provider bill that includes the diagnostic and procedure codes
   - Explanation of Benefits from primary carrier

For questions regarding claims:

Debbie Frick or David Livingston
Roeding Insurance
859-296-4580
1056 Wellington Way, Suite 130
Lexington, KY 40513

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SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills.

Send this claim form, PRIMARY INSURANCE EXPLANATIONS OF BENEFITS, and ITEMIZED BILLS to:

A-G ADMINISTRATORS, INC.
P.O. BOX 979, VALLEY FORGE, PA 19482

Fraud Warning: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see end of the form: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

Name of School ____________ Policy No. US561744 STUDENT'S SOCIAL SECURITY NUMBER ____________

School System ____________ Name of Student ____________

Student Covered: ☐ Schooltime ☐ 24 Hr. ☐ Dental ☐ All Sports ☐ Football Student's Birthdate ____________ Grade ______

Name & Address of Parent or Guardian ____________

1. Date & Time of Accident ____________ ☐ AM ☐ PM
2. COMPLETE details of accident ____________
3. Nature of Injury ____________
4. Did accident occur while:
   (a) Attending school during hours and days school in session? ☐ No ☐ Yes On home premises? ☐ No ☐ Yes
   (b) Traveling to or from school? ☐ No ☐ Yes If yes, was student on usual and direct route? ☐ No ☐ Yes
   (c) Engaged in a school sponsored and supervised activity? ☐ No ☐ Yes Name & place of activity ____________
   (d) Was student participating in an Intramural sport? ☐ No ☐ Yes An Interscholastic sport? ☐ No ☐ Yes What sport? ____________
5. Names and addresses of attending physicians ____________

I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.

SIGNATURE OF SCHOOL OFFICIAL (Required on all claims except 24 hour coverage) ____________ **TITLE** ____________ **DATE** ____________

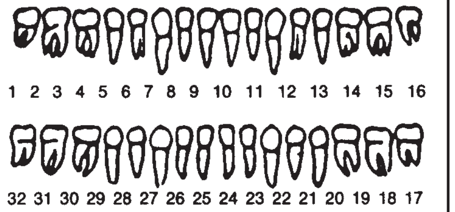
SIGNATURE OF PARENT OR GUARDIAN (Parent please complete reverse side of claim form) ____________ **DATE** ____________

PHYSICIAN'S OR DENTIST'S REPORT

1. Nature of Injury ____________
2. Date of First Treatment ____________
3. Has patient ever had the same or similar condition? ☐ No ☐ Yes If yes, state when and describe ____________
4. Nature of Surgical Procedure, if any & procedure code ____________
5. Dates of Treatment: ____________ Description: ____________ Charge: ____________
6. Has patient been discharged from treatment? ☐ No ☐ Yes If yes, give date ____________

TOTAL CHARGE: ____________

7. Was patient confined to a hospital? ☐ No ☐ Yes If yes, give name & address of hospital & dates confined ____________
8. **TO WHAT OTHER INSURANCE COMPANY HAVE YOU REPORTED THIS CLAIM?** (INCLUDE NAME & ADDRESS) ____________
9. List teeth involved and indicate on chart. ____________



10. Describe condition of injured teeth prior to accident.
   1. CARIOUS ☐ 2. FILLED ☐ 3. WHOLE ☐ 4. CAPPED OR ARTIFICIAL ☐ 5. SOUND & NATURAL

NOTICE OF A LEGAL REQUIREMENT: Insert your Tax Identification Number as required by Section 6041 of the Internal Revenue Code. ____________
(CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.)

COMPANY USE ONLY

PHYSICIAN'S SIGNATURE ____________ **DATE** ____________

PHYSICIAN'S NAME AND ADDRESS ____________
NAME (PLEASE PRINT OR TYPE) ADDRESS

HOSPITAL REPORT (ATTACH ITEMIZED HOSPITAL BILL, IF ANY)

THIS SECTION MUST BE COMPLETED BY PARENT OR GUARDIAN

IF BLUE CROSS (HOSPITALIZATION) GROUP # CONTRACT # SERVICE CODE #	IF BLUE SHIELD (PHYSICIAN'S CARE) GROUP # CONTRACT # SERVICE CODE #
NAME & ADDRESS OF MOTHER'S EMPLOYER	NAME & ADDRESS OF FATHER'S EMPLOYER

DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS? ❑ Yes ❑ No	IF SO, NAME OF COMPANY	POLICY NUMBER

ADDRESS OF OTHER INSURANCE COMPANY NAMED ABOVE	TYPE OF PLAN FROM THIS COMPANY ❑ Individual ❑ Group

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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the school's insurance company to the extent of any amount collectible.

SIGN: Parent or Guardian________________________ Date ____________

If Insured is hospital confined, please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim.

AUTHORIZATION
I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.

Signature ________________________ Date ____________

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.

SIGN: Parent or Guardian________________________ Date ____________

FRAUD WARNING

California & Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York Residents: 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.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.