STUDENT ACCIDENT INSURANCE
2017-2018 SCHOOL YEAR

This is a reminder to parents with a child or children **attending** school in our School District that we do not carry medical insurance on students, but do provide parents with the opportunity to select a primary excess group insurance plan for students. Student accident medical insurance can help you manage out-of-pocket expenses including personal major medical plan deductibles and/or co-insurance. There are two plans available for your consideration:

• **Plan #1 - School Time Coverage (Accident Only)** – Cost $28 per student - This plan provides coverage to your child while he or she is on school premises, during school hours/days, attending school sponsored and supervised activities including travel directly without interruption between the student's residence and school/activity with transportation furnished by the school. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the end of the regular school term.
Excludes all interscholastic sports.

• **Plan #2 - 24 Hour Coverage (Accident Only)** – Cost $124 per student -This plan provides around the clock coverage to your child 24 Hours a day, while he or she is in school, at home or away. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the opening of the next school term.
Excludes all interscholastic sports.

Please note that the plans should be considered in conjunction with any other family medical insurance you may have.

Please see the attached Brochure for a complete description of the plans and the various coverage options. If you have any questions, please do not hesitate to call A-G Administrators directly at (610) 933-0800 between 8:00 a.m. and 4:30 p.m.

PLEASE DO NOT SEND CASH!! Completed applications (found on page six of the attached brochure) must be returned by mail to the below address with your check or money order for the correct premium payable to:

UNITED STATES FIRE INSURANCE COMPANY
c/o A-G Administrators, Inc.
P.O. Box 979
Valley Forge, PA 19482

DO NOT RETURN THE APPLICATION & PAYMENT TO YOUR STUDENT'S SCHOOL

This insurance may be purchased any time during the 2017-2018 school year. Parents enrolling more than one child must fill out an application for each child/student, write a separate check or obtain a money order for each child/student being enrolled and mail in separate envelopes to the above address. Your cancelled check or money order receipt is your proof of payment. Thank you!

K-12 Voluntary Student Accident Insurance up to $250,000

2017-2018

Administrative Office
A-G Administrators, Inc.
PO BOX 979 Valley Forge, PA 19482
Phone (610)933-0800
www.agadministrators.com

Plans are Underwritten by

United States Fire Insurance Company

FAIRMONT SPECIALTY
A member of the Crum & Forster Enterprise

K-12 Accident Insurance

Unexpected Accidents Can Happen

This brochure explains how you can help guard against certain unexpected events. Our plans are designed to help supplement any insurance you have by satisfying deductibles or co-insurance requirements, or limiting the possible financial impacts of an injury if you have no other insurance. Remember that the more active your child is, the more valuable this coverage can be.

Choose Your Coverage Plan

24 Hour Coverage (Accident Only) – This plan provides around the clock coverage to your child 24 Hours a day, while he or she is in school, at home or away. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the opening of the next school term. **Excludes all interscholastic sports.** ($124.00)

School Time Coverage (Accident Only) – This plan provides coverage to your child while he or she is on school premises, during school hours/days, attending school sponsored and supervised activities including travel directly without interruption between the student's residence and school/activity with transportation furnished by the school. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the end of the regular school term. **Excludes all interscholastic sports.** ($28.00)

Description of Benefits

Benefit	24 Hour Coverage/School Time Coverage
Benefits provided for all enrolled students of the Policyholder excluding interscholastic sports for whom premium is paid	
Maximum Benefit:	$250,000
Deductible:	$0
Benefit Period:	52 Weeks
Hospital Services	
Daily Room & Board: Semi Private Room	100% UCR
Miscellaneous Hospital Services: During hospital confinement	100% UCR (not to exceed $10,000)
Intensive Care: When confined to a Hospital Intensive Care Unit	100% UCR
Emergency Room Charges: When hospital confinement is not required	$500 Maximum
Emergency Room Charges: If out-patient surgery is required, the maximum is increased to (The benefits are payable in addition to the X-rays and surgeon's services shown below.)	$2,500 Maximum
Physician Services	
Surgery: including pre- and post-operative care	100% UCR
Anesthesia:	45% of the Surgery Benefit Paid
Assistant Surgeon:	100% UCR
Doctor's Visit: other than for Physiotherapy or similar treatment not payable in addition to Surgery Benefit	100% UCR
Non-Surgical doctor's charges in the emergency room	100% UCR
Second Surgical Opinion, Consultation and Specialists	100% UCR
Laboratory and X-Ray Services	
(Other than Dental and including fee for interpretation and/or reading of X-rays.)*	$28 Unit Value
Lab and X-Ray: (when no fracture is demonstrated)	$700 Maximum
Additional Services	
Physiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat	$60/Visit up to 12 Visits Maximum of $720
Registered Nurse:	100% UCR
Ambulance Transportation: (Ground Only)	100% UCR
Orthopedic Appliances: When ordered by attending physician	$700 Maximum
Out-Patient Drugs and Medication: Administered in Doctor's office or by prescription	100% UCR
Dental (including X-rays): For treatment, repair or replacement of each injured tooth which was sound and natural at the time of injury	$300 per tooth
Eyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact lenses, resulting from a covered injury	100% UCR
Accidental Death Benefit	$2,500
Accidental Dismemberment, Loss of Sight	$20,000
*** In accordance with the 1974 Revised California Relative Values Studies, 5th Addition, using a conversation factor.**	

Policy Exclusions

Benefits will not be paid for a Covered Person's loss which:

(1) Is caused by or results from the Covered Person's own:
   (a) Intentionally self-inflicted Injury, suicide or any attempt thereat. (In Missouri this applies only while sane.);
   (b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);
   (c) Commission or attempt to commit a felony;
   (d) Participation in a riot or insurrection;
   (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
   (f) Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

(2) Is caused by or results from:
   (a) Declared or undeclared war or act of war;
   (b) An Accident which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.);
   (c) Aviation, except as specifically provided in this Certificate;
   (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.
   (e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
      (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
      (ii) The Covered Person was within a 25-mile radius of the site of the release either:
         1) At the time of the release; or
         1) Within 24 hours of the start of the release.

Benefits will not be paid for:

1. Normal health check ups
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
   a. Employed or retained by the Certificateholder; or
   b. Who is the Covered Person or a member of his immediate family;
4. Charges which:
   a. The Covered Person would not have to pay if he did not have insurance; or
   b. Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   a. An aircraft, except as a fare-paying passenger;
   b. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   c. An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
   a. A snowmobile;
   b. Any two or three wheeled motor vehicle;
   c. Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;

8. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is: a. The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
    a. Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food;
11. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;
12. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Certificate;
13. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
14. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
15. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
16. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
17. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
18. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
19. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
20. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
21. Any loss which is covered by state or federal worker's compensation, employers liability, occupational
22. disease law, or similar laws;
23. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
24. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
25. Services and supplies furnished by a Student Infirmary, its employees, or doctors who work for the School;
26. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits; or
27. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound.
28. Rest cures or custodial care;
29. Prescription medicines unless specifically provided for under the Certificate:
30. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;

How to Enroll

1. Determine which plan of coverage you would like to enroll your child in – 24 Hour Coverage Only) or School Time Coverage
2. Fill out the Enrollment Form below, enclose a check or money order in an envelope payable to the Company for the correct amount and mail to A-G Administrators at P.O. Box 979 Valley Forge, PA 19482.
3. Make Checks Payable to UNITED STATES FIRE INSURANCE COMPANY c/o A-G Administrators, Inc.
4. Return by mail to A-G Administrators, Inc. Your cancelled check or money order stub will be your receipt and confirmation of payment. Please write student's name and school name on your check.

INDIVIDUAL VOLUNTARY STUDENT ENROLLMENT FORM
UNITED STATES FIRE INSURANCE COMPANY
STUDENT ACCIDENT COVERAGE

STUDENT'S LAST NAME (one letter per box)

STUDENTS FIRST NAME

Age: _____ Grade: _____ Phone #: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Home Address _____

City _____ State_____ Zip _____

Name of School _____

School District _____

X _____ Date: _____
Signature of Parent or Guardian (Required)

Individual Voluntary Student Accident Plans

24 HOUR COVERAGE

☐ **$124.00 per student**

SCHOOL TIME COVERAGE

☐ **$28.00 per student**

Period of Coverage

Persons applying for coverage shall be covered as of the date premium receipt, but in no event prior to the opening of school activities. Coverage ends at the close of the regular school term, except under 24 Hour Coverage, which continues until school reopens for the fall term. You may enroll at any time, but premiums will not be prorated.

Questions and Answers

Q. Is this Policy primary or secondary coverage?

A. This policy is Primary Excess – meaning A-G will pay the first $100 in valid medical expenses payable without regard to any other valid and collectible insurance plan. Once expenses have exceeded $100, A-G will make payments in excess of any other valid and collectible insurance.

Q. May we purchase the policy at any time during the year?

A. Yes, coverage may be purchased at any point in time during the school year for your child. However, there is no pro-rating of premium for enrollment that occurs after the policy effective date. The earlier you enroll the more your child will maximize their coverage.

Q. Will this policy pay if our other insurance has a deductible?

A. Yes, this policy does not have deductible. You should submit expenses in excess of $100 to your other insurance carriers and forward a copy of the itemized bill and explanation of benefits showing the amount of the deductible.

How to File a Claim

1. Obtain an accident claim form through your school office or A-G Administrators, Inc. Please answer all questions and provide all necessary signatures.
2. Attach all itemized bill(s) and any explanation of benefits to the claim form and mail or fax to the Administrator's Address indicated on the claim form.
3. Claims for benefits must be filed within 90 days from the date of accident. Only one claim form is needed per accident.

Important Note

This brochure is a summary of the insurance plan as specified in the policy form (GA26932-002) on file with the School. This brochure is subject to the terms and conditions of the Policy, which contains all benefits, limitations and exclusions as underwritten by United States Fire Insurance Company. In the event of a discrepancy, the Policy with prevail.

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. _____ 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 _____

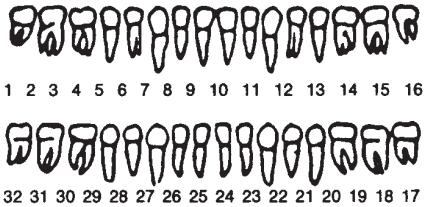
I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.

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.

HOW TO FILE A CLAIM

To process a claim, we will need the following 3 pieces of information:

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

These documents can be emailed, uploaded through our secure A-G Online portal, faxed or mailed to:

A-G Administrators, Inc.
Attn: Claims Department
P.O. Box 979
Valley Forge, PA 19482
(610) 933-4122 Fax
(610) 933-0800 Phone

(800) 634-8628 (Toll Free)
claims@agadm.com

1. The Claim Form enables us 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 an official in your organization such as an administrator, coach, or athletic trainer.

K-12 Claims – Click here

Youth Sports & Other Special Risk Claims – Click Here

College & University Claims – Click Here

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. We typically require a CMS-1500 (HICF) or UB04 form from the provider (they will know what these are). Account statements or "balance due" statements are helpful, but do not contain all the information needed to process the charges.

3. Explanation of Benefits (EOB): 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" (EOB) from that
carrier prior to issuing benefits from this office. If you have no primary medical insurance, the need for an "EOB" will not be applicable to your claim.

REQUEST MORE INFO

In the market for Sports Insurance, but not sure where to start or what to look for? Let us help!

Name:*

Company/School:*

Email:*

Phone:*

SUBMIT FOR MORE INFORMATION

NEED TO REACH US?

Please find our contact information and office hours below should you need to reach us via telephone or email:

Call Us: (800) 634-8628

Email Us: info@agadm.com

Office Hours: Mon-Fri 8:30am-6pm EST

PO Box 979 Valley Forge, PA 19482 | Phone: 610-933-0800