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SHORT-TERM (24-HOUR), COVERAGE

ACCIDENT INSURANCE ENROLLMENT FORM FOR THE *2019-2020* SCHOOL YEAR

100% Participation Required

Provides excess accident and emergency sickness medical coverage and accidental death and dismemberment coverage for all of your students participating in school sponsored and supervised activities involving overnight travel and/or periods without direct and immediate school supervision.

Rate is $1.85/person/calendar day. Coverage consists of the following BASIC and CATASTROPHIC injury benefits.

Basic

Accident medical benefits are paid on an excess basis of 100% of Usual, Customary & Reasonable charges up to $25,000/ injury and $1,000 for Emergency Sickness. Includes benefit for pre-approved Medical Evacuation expenses up to $25,000 and up to $10,000 of expenses for Repatriation of Remains to home country. Covered charges for injuries are limited to those incurred within one year from date of first treatment of the injury or sickness.

Catastrophic

Accident medical benefits are subject to a deductible of $25,000 and are then paid on an excess basis at 100% of Usual, Customary and Reasonable charges up to $1,000,000 with a ten year benefit period. Includes additional cash assistance of up to $500,000 (depending upon the severity of the loss) and accidental death benefit of $25,000.

Crisis Management Benefit.....$100,000 Maximum

If a student is killed as a result of criminal violence while participating in a Covered Activity sponsored and supervised by the School or school district, we will pay the Crisis Management Benefit shown in the Schedule of Benefits to the School or school district involved to help them access the counseling and other care they deem is needed by the student body and staff.

Cosmetic Disfigurement from Burns Benefit..... $150,000 Maximum

If, as a result of a Covered Injury, an Insured suffers third or fourth degree burns in one or more areas of the body, benefits will be paid as determined by the formula specified in the policy.

Special Adaptation Expense Benefit..... $75,000 Maximum

If an Insured suffers a "presumptive disability" from a covered Accident and requires a special housing adaptation or a special vehicle to accommodate the disability.

Traumatic Brain Deficit Benefit..... $250,000 Maximum

If an Insured suffers an injury to the brain which 1) occurs, and is diagnosed by a Doctor; 2) results in measurable, neurological deficit persisting for the lesser of at least 12 consecutive months or the time at which maximum recovery has been reached; 3) requires permanent daily personal supervision; and 4) results in the inability of the Insured to perform independently three or more of the following activities of daily living: a) transferring (moving in or out of a bed or chair); b) dressing; c) bathing; d) feeding; e) toileting; or f) continence.

Underwritten by ACE American Insurance Company.

The policies have complete details of provisions, definitions, limits and exclusions.

INSTRUCTIONS - Complete Enrollment Form on Reverse

The fully completed enrollment form and roster of participating students (and coaches/instructors) must be received by us prior to the start date of activities. Otherwise, coverage will begin upon receipt. Premium is due within 10 days of the start of the activity. It is required that all students attending this event are covered, whether they have other insurance or not.

Coverage is optional for parent volunteers and other youth participants. Staff may also be included on an optional basis.

Mail, fax or email to: Myers-Stevens & Toohey & Co., Inc. - 26101 Marguerite Parkway Mission Viejo, CA. 92692
Via Fax – (949) 348-2630 • Via Email – activities@myers-stevens.com

QUESTIONS??? Call (800) 827-4695

ENROLLMENT FORM

ACTIVITY INFORMATION

Name of District _____

Name of School _____

Address _____ Phone _____

E-mail Contact _____

Starting date _____ Ending Date _____

Destination/Activity _____

Coverage requested by:

_____ _____ _____

Print Name Signature Date

PLEASE NOTE: THERE IS A MINIMUM PREMIUM REQUIREMENT. Premium is due within 10 days of the start date of activity.

PAYMENT/BILLING INFORMATION

NEW ( ) REVISED ( )

Calculate Premium Due: _____ x _____ x $1.85 = $ _____

# of Participants # of Calendar Days Premium Rate PREMIUM DUE ($35 minimum)

METHOD OF PAYMENT: ( ) CREDIT CARD (see below) ( ) CHECK NUMBER _____ ( ) P.O. NUMBER _____

If paying by credit card, complete below. Your amount of charge will appear as "MYERS-STEVENS & TOOHEY 800-827-4695 CA" on your statement.

MC: ( ) VISA: ( ) _____ - _____ - _____ - _____ _____ _____

Month / Year Security Code

I authorize Myers-Stevens & Toohey & Co., Inc. to deduct the premium payment, plus a 3% processing fee:

Name of Cardholder _____ Cardholder's Signature _____

LIST STUDENTS / PARENT VOLUNTEERS & OTHER YOUTH PARTICIPANTS / STAFF

Please provide names below. If necessary, please make copies and attach separately.

Students

	Last Name	First Name		Last Name	First Name
1.			14.		
2.			15.		
3.			16.		
4.			17.		
5.			18.		
6.			19.		
7.			20.		
8.			21.		
9.			22.		
10.			23.		
11.			24.		
12.			25.		
13.			26.		

Parent Volunteers and Other Youth Participants

Last Name	First Name

Staff

Last Name	First Name

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Student Accident & Sickness Insurance
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)

Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. These may be found in policies on file with school authorities, printed brochures used to secure coverage, online or by contacting us directly at (800) 827-4695.

Claim form and reporting

Report school related injuries immediately to school officials, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school and ask an authorized school official to COMPLETELY AND LEGIBLY fill out Part A of the form. If the reported injury is not school-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.

COMPLETELY AND LEGIBLY fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.firsthealth.com (800) 226-5116 or www.fchn.com (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.

When treatment is sought

Give the provider's billing/admissions person your primary insurance/health plan information (if applicable).

If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school, let the billing person know that and identify the school/school district. In either case, explain that your child's coverage is "secondary accident medical expense insurance" or accident & sickness insurance and that it is NOT what is sometimes referred to as "third party" insurance. Your child is the insured.

Ask the billing person to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

MYERS-STEVENS & TOOHEY
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

OR Fax: (949) 348-9350 *OR* Email: claimsinfo@myers-stevens.com

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Need more help? Call us at (800) 827-4695

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STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (Parent or legal guardian may complete Part A if injury is not school related)

NAME OF CLAIMANT FIRST	MI	LAST	AGE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO / DAY / YR

ADDRESS OF CLAIMANT	CITY	STATE	ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____	ID # FROM ID CARD (If applicable)
NAME OF SCHOOL	NAME OF DISTRICT (if applicable)
SCHOOL MAILING ADDRESS CITY STATE ZIP CODE	INJURY ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom OCCURED: ☐ Travel ☐ At Home ☐ Field Trip ☐ Other _____
WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL SPONSORED AND SUPERVISED? ☐ YES ☐ NO IF YES, LIST NAME OF SPORTS ORGANIZATION:	DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? YES ☐ NO ☐ If YES, name of plan:

DATE OF INJURY/SICKNESS MO / DAY / YR	TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)	WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT	HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY	WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO	DATE SCHOOL WAS NOTIFIED / /

NAME AND TITLE OF OFFICIAL COMPLETING FORM	SIGNATURE X	DATE SIGNED	SCHOOL TELEPHONE NUMBER ( )

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN	ADDRESS	PHONE NUMBER ( )

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO IF YES, NAME OF PLAN(S)	POLICY NUMBER(S)

NAME OF CLAIMANT'S EMPLOYER (if applicable)	ADDRESS	PHONE NUMBER ( )

NAME OF FATHER OR LEGAL MALE GUARDIAN	MOBILE TELEPHONE NO. ( )	HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN	MOBILE TELEPHONE NO. ( )	HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

AUTHORIZATION: *I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey & Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.*

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

ASSIGNMENT OF BENEFITS: *I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.*

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

FRAUD WARNING: *Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.*
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

STATE-SPECIFIC FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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: 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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: 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 $5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with 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 is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

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

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Underwritten by: ACE American Insurance Company

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PPO Network - *WA*