CHRISTIAN BROTHERS SERVICES

Understanding Protecting Guiding

Send claims to:

A-G Administrators, Inc.
P.O. Box 979
Valley Forge, PA 19482

Phone: 610.933.0800
Fax: 610.933.4122
www.agadministrators.com

2017-2018 NOTIFICATION OF INJURY FORM

PART I Must be Completed in full by an Authorized School Representative

Student Name: Last First MI			
Student Address, City, State, Zip:			
Student Social Security #	Date of Birth:	Grade:	Sex: ☐ M ☐ F

Description of Injury (Provide details, indicate injured body part–e.g. broken arm, sprained ankle) **MUST BE BODILY INJURY DUE TO ACCIDENT:**

Accident Date:	Did accident occur:
Place:	• Traveling to/from school or school-sponsored activities? ☐ Y ☐ N
Activity:	• During school hours? ☐ Y ☐ N
	• During a school activity? ☐ Y ☐ N

Signature of Authorized School Representative:	Title:	Date:

PART II Must be Completed in full by the Parent/Guardian

Father's/Guardian Name:	Email Address:
	Phone Number:
Name of Employer:	
Mother's/Guardian Name:	Email Address:
	Phone Number:
Name of Employer:	

Is student covered by a Medical Plan	☐ Yes	☐ No

If yes, please provide the following information about the insurance company or companies:

Name of Insurance Company:

Policy or Plan Number:

Policyholder's Name:

Relationship to Student:

Is the student eligible for Medicaid or TriCare benefits? ☐ Yes ☐ No
If yes, please file for benefits under the Student Accident Plan before submitting expenses to Medicaid or TriCare.

Authorized signature(s) required on page 2 of this form

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.

Signature of Parent/Guardian: _____ Date: _____

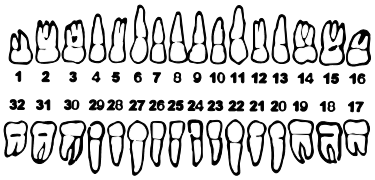
Authorization: I hereby authorize any medical provider who treated or attended the above student to furnish Christian Brothers Student Accident Plan or its representatives any information requested. A photocopy of this authorization is to be considered valid.

Signature of Parent/Guardian: _____ Date: _____

Coverage will be immediately rescinded in the event of any person knowingly filing a statement of claim containing false, incomplete or misleading information.

STATEMENT OF DENTAL INJURY
Must be Completed by Attending Dentist

1. Describe exact nature of injury. Identify teeth involved in the accident and indicate on chart.



_____

_____

_____

2. Nature of treatment:

_____

_____

_____

3. Condition of injured teeth prior to accident (check those that apply):

☐ Vital ☐ Whole ☐ Sound ☐ Filled ☐ Capped ☐ Artificial

Signed: _____ **Date:** _____ **Degree:** _____

Address: _____

Street City - State - Zip Code

Quick Reference - Claims Procedure

School's Responsibility

- Complete Part I (school's portion) of the Notification of Injury Form in full, including signature.
- Give the Notification of Injury Form in its entirety to the parent/guardian as soon as possible for completion of the parent's portion Part II.
- Never give a student, parent/guardian or medical provider a blank form.

Parent/Guardian's Responsibility (See Page 3 for detailed information)

- Complete Part II (parent/guardian portion) of the Notification of Injury Form in full, including signatures and send directly to **A-G Administrators, Inc., P.O. Box 979, Valley Forge, PA 19482**
- If you are employed, but have no insurance, we must receive a letter to that effect on the employer's letterhead.
- This form should be sent to **A-G Administrators, Inc.** as soon as possible, and must be received within 180 days of date of injury.
- Treatment must commence within thirty (30) days of the accident by a licensed physician.
- If injury is dental related, Statement of Dental Injury must be completed by dentist.
- Send itemized medical bills **and** the corresponding Explanation of Benefits (EOB) or notices of denial from primary insurance(s) within 180 days of treatment.
- Make sure the physicians and the other providers of service send all subsequent itemized bills to the address on the top of this Notification of Injury form.

PLEASE KEEP PAGE 3 & 4 FOR YOUR RECORDS

CHRISTIAN BROTHERS SERVICES STUDENT ACCIDENT PLAN
PLEASE KEEP THIS PAGE FOR YOUR RECORDS

The Student Accident Plan is a program designed to reimburse parents/guardians for out-of-pocket expenses incurred from hospital, physician, and other medically necessary eligible expenses which occur as a result of an accident to their dependent child who is a full-time registered student in a school which has agreed to participate in the Religious and Charitable Risk Pooling Trust. The Plan is an "Excess" Plan over other valid coverage, as explained below.

HOW TO REPORT AN INJURY AND INITIATE THE CLAIM PROCESS

To qualify for reimbursement for the benefits provided the Eligible Expenses must be for Medically Necessary Care and exceed the amounts for which a Covered Student is entitled to reimbursement by other valid insurance or health agreements. Please reference the **Non-Duplication or Excess Provision** on the page 4.

Treatment must commence within thirty (30) days of the accident by a licensed physician. All medical/dental expenses are only reimbursable if incurred within one hundred and four (104) weeks from the date of injury. All bills must be submitted within one hundred eighty (180) days of treatment.

Submit the medical expenses to all other valid coverage available to or on behalf of the Student. This includes, but is not limited to, group or individual accident and health plans, prepaid for service plans, HMO's and provisions under the No-Fault Insurance Statute, including the self-insured equivalent of any minimum benefits required by law.

The following information must be received by the Plan Administrator for payment consideration:

1. Notification of Injury form provided by the school. Part I of this form must be completed and signed by an authorized school representative. Part II of this form must be completed and signed by the parent/guardian and submitted within 180 days of the injury. If injury is dental related Statement of Dental Injury must be completed by dentist

   and

2. Copies of all itemized bills showing the provider's name, address, tax ID number and diagnosis and procedure codes. You can request copies of itemized bills from any provider. Receipts and statements are not valid

   and

3. Explanation of Benefits or denial letter from the primary insurance carrier(s).

The unpaid portion of the charges will be considered for payment and paid in accordance with the terms of the Plan. Benefits can be paid to the medical provider if the parent/guardian sends written authorization to pay the provider directly; otherwise payments will be made to the parent/guardian. If the parent/guardians are employed, but have no insurance, we must receive a letter to that effect on the employer's letterhead.

Send all claims and information to:

A-G Administrators, Inc.
P.O. Box 979
Valley Forge, PA 19482

Phone: 610.933.0800
Fax: 610.933.4122
Email: claims@agadm.com

Questions regarding payments or claim status can be directed to:

610.933.0800

MEDICAL COVERAGES & LIMITATIONS
PLASE KEEP THIS PAGE FOR YOUR RECORDS

Treatment must begin within 30 days of an accident by a licensed physician. Coverage is included up to the Usual, Reasonable, and Customary Charges for eligible medical care expenses incurred for medically necessary care as a result of an accident which occurs while a student is participating in a covered activity, with a limitation of $25,000 for each accident per benefit period not to exceed 104 weeks. Coverage includes licensed hospital, physician, nursing, lab, x-ray and other eligible medical expenses. Hospital room and board charges are limited to the most common semi-private rate of the hospital. Dental treatment is limited up to $1,000 per tooth. Confinement, treatment, or services to diagnose, prevent, or correct craniomandibular or temporomandibular joint disorders are limited to $1,000 per accident. Orthodontics limited to $2,500 per accident. Chiropractic and acupuncture treatment is limited to $50 per visit and $300 per covered accident. Physical therapy and Occupational therapy are limited to $1,500 per covered accident. Ambulance/air ambulance to nearest treatment facility, not to exceed $1,000 per accident. Durable Medical Equipment (DME) limited to $1,500 per accident. Therapy arising out of closed head injury limited to $2,500 per accident.

Other Benefits

- $2,500 for accidental loss of life.
- $2,500 for accidental loss of both hands, both feet, both eyes, or any combination thereof.
- $1,250 for the accidental loss of one hand, one foot, or one eye.

Non-Duplication or Excess Provision

Reimbursements for eligible expenses are limited to those expenses that are in excess of other valid coverage available to or on behalf of the Student for which the student and/or parent/guardian are legally obligated to pay. This includes, but is not limited to, group or individual accident and health plans, prepaid for service plans, HMO's, and provisions under the No-fault Insurance Statute, including the self-insured equivalent of any minimum benefits required by law.

If a student has coverage through an HMO, PPO, or similar arrangement, that plan must be used correctly or medical benefits under this Plan shall be reduced by 50%. If a Plan, representing other valid coverage available contains a similar non-duplication or excess provision of this Plan, reimbursement for eligible expenses will be shared on a 50/50 basis between the Plans.

Exclusions

This Plan does not cover expenses for (a) eyeglasses, contact lenses, or hearing aids; (b) intentionally self-inflicted injuries, suicide or any attempt thereof; committing or attempting to commit a felony; (c) injury or loss sustained due to the use of alcohol or drugs, unless taken under the advice of a physician; (d) disease or bacterial infection (except pyogenic infections due to accidental cut or wound); (e) hernia in any form; (f) accidental bodily injury occurring prior to the period of coverage; (g) illness or disease in any form; (h) any loss which is payable under any Workers' Compensation Law or Employers' Liability Law; (i) any injury caused by air travel, or injuries occurring while operating, learning to operate, or serving as a member of the crew of any aircraft, except as a fare-paying passenger on a regularly scheduled commercial airline, or any accident where the insured is the operator and does not hold a valid motor vehicle operator's license (except in a Driver's Education Program); (j) travel in or upon any 2 or 3 wheel motor vehicle; (k) any injury that is caused by war or any act of war, or caused by taking part in a riot; (l) injuries resulting from participating in any activity which is excluded from the Coverage Plan selected by the Participating Institution including practice sessions or travel directly to or from such activities; (m) any part of a charge for confinement, treatment, or service that exceeds usual, reasonable and customary charges; (n) treatment by persons employed or retained by the participating school, or by any member of the student's immediate family; (o) re-injury or complications of a condition due to accidental bodily injury occurring prior to the effective date of the school's participation (p) injuries sustained from repetitive use or over use of a body part; (q) the Plan does not provide accident coverage to any activity which is not sponsored by the Participating Institution.

This is a partial description of the coverage provided by the Student Accident Plan.
Complete terms and conditions are contained in the Plan Document on file with the Participating Institution.

Neither the Plan, the Plan Sponsor, the Trustees, nor any member of the Administrator will be responsible for the false or misleading statements and/or assurances with regards to the coverages afforded under this Trust Plan that are made by the member institutions and/or its employees and representatives. Member Institutions are bound by the coverage terms and conditions as described in the Plan Document.