[illegible] 8[illegible] 9[illegible]

This is a reminder to parents with a child or children [illegible] 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 group insurance plan for students. Student accident insurance can help you manage the possibility of out-of-pocket expenses, since many group insurance policies no longer pay full hospital and medical expenses and may require a deductible or co-insurance. There are two plans available for your consideration:

- [illegible] – Costs $22 per student – This will cover injury occurring while the student is traveling to and from school, while attending school sponsored activities such as plays, assemblies, class trips, intramural sports, gym and physical education classes, etc.

- [illegible] – Costs $88 per student – This will cover all of the above, plus accidents occurring away from school, in the evenings and on weekends, vacations, etc.

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 call an Insurance Broker at Alive Risk directly at (215) 946-8888 between 8:00 and 4:30 p.m.

[illegible]

A&H Lockbox
P.O. Box 45731
Baltimore, MD 21297

[illegible]

This insurance can be purchased anytime during the 2018-2019 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 address above. Your cancelled check or money order receipt is your proof of payment. Thank you!

Up to **$1,000,000** Student Accident Medical Insurance Protection

Administered By:

ALIVE RISK

Fairless Hills, PA

(215) 946-8888

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AXIS Insurance Company

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BEST BUY

24-HOUR COVERAGE

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SCHOOL TIME ACCIDENT COVERAGE

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ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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ACCIDENTAL DENTAL CARE AND SURGICAL BENEFIT

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IMPORTANT NOTICE

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STUDENT ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 ACCIDENT MEDICAL EXPENSE BENEFITS

[illegible]

PRIMARY COVERAGE

[illegible]

Covered Expenses: [illegible]

Intensive Care Unit [illegible]

Semi-Private Room: [illegible]

Personal Services and Supplies: [illegible]

Inpatient X-ray, CT scan, MRI: [illegible]

Inpatient Laboratory Tests: [illegible]

Hospital Miscellaneous Expenses: [illegible]

In-Hospital Physiotherapy: [illegible]

Nurse Services: [illegible]

Orthopedic Appliances: [illegible]

Pre-Admission Tests: [illegible]

Ambulatory Medical Center: [illegible]

Emergency Room Treatment (when Hospital Confinement is not required): [illegible]

Physician Services: [illegible]

Surgery: [illegible]

Assistant Surgeon: [illegible]

Second Opinion or Consultation: [illegible]

Anesthesia and its Administration: [illegible]

In-Hospital Visits: [illegible]

Office Visits: [illegible]

Outpatient X-ray, CT Scan, MRI: [illegible]

Outpatient Laboratory Tests: [illegible]

Outpatient Physiotherapy: [illegible]

Outpatient Nursing Services: [illegible]

Ambulance Services [illegible]

Dental Services: [illegible]

Prescription Drugs [illegible]

[illegible]

Exclusions apply to the Accident Medical Expense Benefit and the Accidental Death and Dismemberment Benefit:

[illegible]

LIMITATIONS: [illegible]

[illegible]

NOTE: [illegible]

To File A Claim:

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MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

ENROLLMENTFORMCHECKLIST

Did You:

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For questions, inquiries, and information contact:

Ali□e □is□
Fairless Hills, PA
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DO NOT SEND CASH

Enrollment Form

Please Print

Pennsylvania 2018-2019

STUDENT'S LAST NAME

STUDENT'S FIRST NAME | MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) | GRADE | PHONE

HOME ADDRESS | APT#

CITY | ST | ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.

SIGNATURE OF PARENT OR GUARDIAN | DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – 2018-2019 – CHECK ✓ YOUR SELECTION

Coverage Plans	Premiums
BEST BUY! 24-Hour	☐ $88.00
School Time	☐ $22.00
Dental Accident Insurance (with either of the above plans)	☐ $8.50

Make checks payable to:

Alive Risk

How to Enroll

1. Decide whether you want the School time, 24-Hour Accident Protection or Dental Plan.
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to the Administrator shown for the correct amount.
3. Mail envelope to A&H Lockbox – PO Box 45731 –Baltimore, MD 21297
   Your cancelled check or money order stub will be your receipt and confirmation of payment. (Please write the student's name and school name on your check.)

BACC-004-0909

MEDICAL CLAIM FORM

[illegible] (box, top left) *

P.O. BOX 6540

HARRISBURG, PA 17112

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A [illegible]

Name [illegible] District / College / Organization	Individual [illegible] Team	[illegible]
Address [illegible] Street	City	State
Zip	Area Code Telephone	Date of Birth (MO DAY YR)
Name of Injured Person	Date of Birth (MO DAY YR)	Social Security No.
Age	Grade	MALE ☐ FEMALE ☐

Injury Occurred: Practice ☐ Game ☐ [illegible] ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Intersc[illegible] ☐ Intercollegiate ☐

Time of Injury: [illegible]

Describe in detail How the injury occurred [illegible] (please attach a [illegible] report)

Part of the body was injured (left or right side if applicable) — [illegible]

At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐

Name of Supervisor [illegible] Organization Official — Was there a witness to accident? Yes ☐ No ☐

Signature [illegible] Organization Official — Title of Official — Date Signed (MO DAY YR)

PART B [illegible] PAR[illegible] [illegible]

Name of Mother/Father or Guardian	Social Security No.	Relationship to insured: Father ☐ Mother ☐ Guardian ☐ Self ☐
Address [illegible] Street [illegible]	City	State / Zip Code
Area Code Home Telephone Number	Father's Work Telephone	Mother's Work Telephone
Occupation of Father or Mother, Wife or Husband	Place of Employment	Address of Employer
Occupation [illegible]	Place of Employment	Address of Employer

Do you have any other health and/or accident insurance plan other than this plan? Father ☐ Yes ☐ No — Mother ☐ Yes ☐ No — Husband ☐ Yes ☐ No — Wife ☐ Yes ☐ No — Self ☐ Yes ☐ No

Is the injured person covered by other health and/or accident insurance plan? ☐ Yes ☐ No — Effective Date (MO DAY YR)

Name of other health and accident insurance company: [illegible]

Address of Insurance Company — Policy Number — Phone

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

[illegible]

Signature of Insured or Authorized Representative — Dated

Address

A[illegible] PA[illegible] Medical [illegible] Physician or Supplier for Services described on the reverse side and/or attached.

Date — Signature of Responsible Party or [illegible] Years Old

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1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.

2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.

3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: MCA Administrators, Inc. for processing: paid receipts and/or balance due statements are not accepted.

4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

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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 and subjects such person to criminal and civil penalties.

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1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).

2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.

3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)

5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.