

This is a reminder to parents with a child or children enrolled 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:

- Student Accident Insurance 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.
- Student Accident and Sickness Insurance 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.

Student Accident Insurance covers injuries 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.

□

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

Student Accident and Sickness Insurance covers all of the above, plus accidents occurring away from school, in the evenings and on weekends, vacations, etc.

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



Order Form
AXIS Insurance Company
Chicago, Illinois

Ver. 4

To File A Claim:

- Read and understand a claim form, and [submit a claim as described below](#)
- Fill out Parts A and B
- Be sure to sign and date the form
- Attach a copy of billed bills or receipts for services rendered
- Send claim forms, itemized bills and receipts to:

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

ENROLLMENT FORM CHECKLIST

Did You:

- Fill out all the appropriate information on the enrollment form (MA or H or A or AH or MAH or MAHA)
- Attach the appropriate forms for the coverage you have selected
- Attach a H or M or MA or MAH or MAHA or the Mail Premium form (cancelled coverage or pre-order service as appropriate) and email or mail the completed enrollment information to the appropriate address

For questions, inquiries, and information contact:

Alice Wis
Fairless Hills, PA
 (800) 427-9308
 (800) 427-9308

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 | | |
| <p>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.</p> | | |
| 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 | | Premiums |
|--|--|----------------------------------|
| Coverage Plans | | |
| BEST BUY! 24-Hour | | <input type="checkbox"/> \$88.00 |
| SchoolTime | | <input type="checkbox"/> \$22.00 |
| Dental Accident Insurance (with either of the above plans) | | <input type="checkbox"/> \$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

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.

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.

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.