[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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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

The Company will pay the Usual and Customary Charges incurred for a Covered Injury, if first treatment is received within [illegible] days after the Injury. The Schedule of Benefits is stated below. Benefits are payable up to a maximum of [illegible] weeks after the date of the Covered Injury.

PRIMARY COVERAGE

Benefits are payable for covered medical expenses from the first dollar, no deductible, no coinsurance, payable in addition and without regard to payments by other insurance up to maximums stated herein. Benefits are payable for a maximum of [illegible] weeks.
Total Maximum for all Accident Medical Benefits: [illegible]

Covered Expenses: Determination of the amount of each covered expense, and where applicable, each usual and customary charge, will be made solely by the Company.
Intensive Care Unit: Usual and Customary Charges, not to exceed [illegible] per day for [illegible] days
Semi-Private Room: Up to [illegible] per day
Personal Services and Supplies: Usual and Customary Charges
Inpatient X-ray, CT scan, MRI: Up to a maximum of [illegible]
Inpatient Laboratory Tests: Up to a maximum of [illegible]
Hospital Miscellaneous Expenses: Usual and Customary Charges up to [illegible]
In-Hospital Physiotherapy: Usual and Customary Charges, up to a maximum of [illegible] visits
Nurse Services: Usual and Customary Charges
Orthopedic Appliances: In Hospital: up to a maximum of [illegible]; Out of Hospital: up to a maximum of [illegible]
Pre-Admission Tests: Usual and Customary Charges
Ambulatory Medical Center: Usual and Customary Charges
Emergency Room Treatment (when Hospital Confinement is not required): Up to a maximum of benefit [illegible]
Physician Services: Usual and Customary Charges
Surgery: Usual and Customary Charges in accordance with the [illegible] Revised California Relative Value Studies, [illegible] Edition, maximum of a conversion factor [illegible] per unit value
Assistant Surgeon: [illegible] of Surgery Allowance
Second Opinion or Consultation: Up to a maximum of [illegible]
Anesthesia and its Administration: [illegible] of Surgery Allowance
In-Hospital Visits: Usual and Customary Charges
Office Visits: Usual and Customary Charges
Outpatient X-ray, CT Scan, MRI: Up to a maximum of [illegible]
Outpatient Laboratory Tests: Up to a maximum of [illegible]
Outpatient Physiotherapy: [illegible] per visit, up to a maximum of [illegible] visits
Outpatient Nursing Services: Usual and Customary Charges
Ambulance Services (Air and Ground): Usual and Customary Charges
Dental Services: [illegible] per tooth / Usual and Customary Charges for braces
Prescription Drugs: Usual and Customary Charges

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:
1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Loss;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses; or
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

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

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Policy. The Policy does not cover any Covered Loss incurred as a result of:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission of or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. parachuting;
7. travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not Accidental, to viral, bacterial or chemical agents; whether the loss results directly or indirectly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. injuries compensable under Workers' Compensation law or any similar law;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including traveling to and from games and practice, unless specifically provided for in the Master Insurance Application;
13. participation in any sports activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal school hours, including skateboarding, skiing and ice hockey;
14. benefits will not be paid for services or treatment rendered by any person who is:
   a. employed or retained by the Policyholder;
   b. living in the Insured Person's household;
   c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's spouse; or
   d. the Insured Person.

LIMITATIONS: any covered injury occurring, and expenses incurred therefrom, as a result of a Covered Accident which occurs while an Insured Person is engaged in an activity which is covered under the [illegible] Plan, will not be covered under a Voluntary Plan.

When excess insurance is provided and another Plan Providing Medical Expense Benefits to an Insured is an HMO, PPO, or similar arrangement for provision of benefits or services and the covered accident occurs within the geographic area of the HMO, PPO, or similar arrangement for provision of benefits or services and the Insured does not use the facilities of the HMO, PPO, or similar arrangement for provision of benefits or services, the medical benefits otherwise payable under the policy shall be reduced by [illegible]. This limitation shall not apply to emergency treatment required within [illegible] hours after an accident or when the covered accident occurs outside the geographic area served by the HMO, PPO, or similar arrangement for benefits or services.
This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

NOTE: This provision is intended not to unfairly reduce benefits for any Insured if the Insured is outside the Service Area of the HMO, PPO, or similar arrangement for benefits or services and no benefits are available. The reduction of benefits is only for those Insured Persons who can use their HMO, PPO, or similar arrangement for benefits or services and have chosen not to.

To File A Claim:

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

ENROLLMENTFORMCHECKLIST

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For questions, inquiries, and information contact:

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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

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 of School District / College / Organization	Individual Sport / Team	
Address	City	State / Zip / Area Code Telephone / Date of Birth (MO DAY YR)
Name of Injured Person	Date of Birth / Social Security # / Age / Grade	MALE ☐ FEMALE ☐
Injury occurred: Practice ☐ Game ☐ Play ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐		Time of Injury
Describe in detail how the injury occurred. Please attach a report if additional space is needed.		
Part of body injured (right or left side if applicable)	Date of Injury	
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 / Official	Was there a witness to accident? Yes ☐ No ☐	
Signature of School or Organization Official	Title of Official	Date Signed (MO DAY YR)

PART B [illegible]

Name of Mother / Father or Guardian	Social Security #	Relationship to Insured: Father ☐ Mother ☐ Guardian ☐ Self ☐
Address (Number, Street or Apt.)	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	Place of Employment	Address of Employer
Do any of the above have 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	
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

[illegible] Medical benefits [illegible] Physician or Supplier for services described on the reverse side and/or attached.

Date — Signature of Responsible Party for Students Under 18 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.